I am a Sexual Health and HIV consultant working at University Hospital Plymouth trust. I thank you for taking the time to conduct this important inquiry. I am putting forward this submission as I believe passionately in provision of a holistic and inclusive sexual health service. Recipients of this service do not have much of a public voice so I would like to raise mine on their behalf.

Plymouth is a city with considerable levels of deprivation and higher than average proportion of young people. We have STI rates that are the 28th highest of 326 local councils in England. We have the highest diagnosis rates of Chlamydia among <25s in the Southwest. Rates of gonorrhoea diagnosis have more than doubled in the past 4 years. Like other services we have seen a rise in azithromycin resistant strains of Gonorrhoea and have amended our testing and treatment protocols to manage this. We currently do not know our prevalence rates or rates of resistance for Mycoplasma Genitalium as testing has been restricted due to financial constraints and resistance testing is not available for the same reasons.

We are a low prevalence area for HIV but we have high rates of late diagnosis, possibly linked to low levels of local professional and population awareness.
There has been a determined focus on reducing teenage conceptions over the last decade. The rate of teenage conceptions in Plymouth has fallen significantly from 54.7 per 1,000 females aged 15-17 in 1998 to 19.6 in 2016.

**Diagnosis, Prevention and treatment:**

As a **clinical sexual health service**, we offer a holistic approach which aims to optimize an individual’s and our local populations’ sexual health. The following are a selection of clinical conditions which we are specialized to manage:

- The treatment of STIs and their complications such as pelvic inflammatory disease and epididymitis.
- Provision of all forms of contraception including long acting methods and emergency contraception.
- Genital pain syndromes (including vulval pain, chronic pelvic pain in men and women)
- Recurrent genital conditions not related to STIs such as recurrent candidiasis and Bacterial vaginosis.
- Medical management of victims of sexual assault.
- Advice and referral for those with psychosexual issues.
- Diagnosis and management of genital dermatological conditions that can have a detrimental impact on sexual health, general well-being and carry a risk of malignancy including lichen sclerosis.
- Diagnostic work-up of conditions which can present in as similar way to STIs, including urinary tract infections, testicular and epididymal lesions, balanitis, endometriosus and other causes of pelvic pain.

We work closely with our local commissioners and other sexual health providers (whom we sub contract) to increase access to those at greatest risk of sexual ill health and those with less ability to access mainstream services.

- We are expanding our community clinic and outreach work. In the past 2 years we have established an LGBT+ clinic in the city centre, a <25s service within a young people’s hub in the city and a homeless person’s clinic in a city centre hostel.
- We are about to launch our locally developed on-line screening service. As an extension of this will be training those who work with the most vulnerable in our city to help them to access this testing via those services.

In addition to these clinical services we put a lot of emphasis and resources into **health promotion and prevention** through activities including:

- Vaccination against Hep A/ B (and soon HPV vaccination in MSM <45)
- Contact tracing for STIs to ensure that for each person who is diagnosed and treated for an STI their partners who are at risk are also contacted and offered testing and treatment as appropriate.
- Screening all young people for risk of child sexual exploitation and management of this risk through the multidisciplinary team (safeguarding)
- Screening for domestic abuse, management of this risk through the multidisciplinary team and onward referrals
- Provision of post exposure prophylaxis to those at recent risk of HIV acquisition
- Provision of monitoring and regular screening for those self-providing pre-exposure prophylaxis against HIV (PrEP) in addition to those on the IMPACT study.
Brief interventions to reduce risk behaviours including high risk sexual behaviours, alcohol, smoking and drug use.

With increasing demand on services as described below, a reducing budget and a restrictive service specification where many of the above services are not commissioned we are having to look at restricting our offer to patients.

Anecdotal evidence, in our clinic, suggests where time is a restrictive factor, we focus on the immediate management of the clinical presentation while valuable preventative work and screening for other risks such as CSE are sacrificed.

**Demand:**

Demand for our service is increasing annually. We have over 20,000 attendances at our clinical sexual health service annually and this is increasing year on year.

The complexity of patient presentations is increasing. This is in the context of an overburdened and understaffed primary care system locally. Increasingly people are being triaged over the phone from primary care, being advised to present to our open access service for any issue related to sexual health or to the pelvic/genital area. A significant number of my consultations begin with ‘I was advised to come by my GP practice...’ or ‘I could not get an appointment with my GP...’.

Increased awareness among staff around issues such as CSE and Domestic abuse, which is a very positive thing, adds to complexity of managing our patients.

For men who have sex with men great advances in prevention such as PrEP and HPV vaccination will and are currently adding to the burden of our workload.

This increase in demand together with the improvement in access which I have outlined in the previous section is occurring on the backdrop of significant financial cuts to our service, a complex commissioning system and a time and resource consuming cycle of service tendering.

Staff are currently stretched to their absolute limit and we are now at the stage where we have to look at restricting access to our service. We are an open access service, to which the majority self-refer. There are no effective evidence-based models for triaging those presenting to an open access sexual health service. Triage risks delaying access to treatment, with attendant risks of complications and infection spread. Patients will be diverted to an overstretched emergency department or primary care. We have evidence of poor management of STI and non STI related conditions (listed above) above in both these settings. We who are specialized in sexual health are best placed to manage these conditions effectively and efficiently.

**Access and funding**

We are a co-located sexual health, pregnancy advisory and HIV treatment service. As you are aware each of these services is commissioned separately; We are commissioned by 3 local authorities, 2 CCG and STP areas and NHS England respectively. WE Negotiation of contracts has consumed large amount of management and senior clinician time, diverting resources away from the front line. We were engaged in an 18-month tender process for our contract with Plymouth local authority. We succeeded in winning an internal tender where we subcontract to 3 other providers of sexual health, prevention and support services. Ongoing management of this sub contracts is time consuming and accountability and risk sits with our NHS trust.
We face a cumulative reduction in our budget of 22% over the next 3 years and the local authority envisage these reductions to continue after this.

We cannot continue to provide the current level of service in addition to newer innovative services described before with these reductions.

New services such as on-line testing was speculated to reduce costs in the long term but there is no evidence for this and anecdotal evidence is that it increases demand and testing by lower risk individuals.

Another premise for reducing spending was the diversion of patients back to primary care. The reality is that with a burgeoning primary care service locally the flow has been in the opposite direction. There is a wealth of experience and expertise within our service whose staff have dedicated their professional careers to training in sexual health medicine. We are best placed to manage all the conditions listed above.

The placement of sexual health within Public health and local authority budgets, means that service specifications are narrowly focused on key public health outcomes such as Chlamydia rates in <25s and unplanned pregnancy rates and do not reflect the complexity of issues that we see and manage on a daily basis. Furthermore, it means that this NHS based clinical service does not have its budget, a fact which the public are completely unaware of.

**Standards**

We have always followed national standards and guidelines produced by our professional organisations: BASHH, BHIVA and FSRH.

This is a commitment we cannot make with certainty in the future. A recent example being that of Mycoplasma testing, resistance testing and treatment which has been recommended in recent European and British guidelines on management of PID, NSU and epididymo-orchitis. Funding for mycoplasma testing is not commissioned currently. We can not secure funding to introduce a test locally at this time. The risks associated with not testing include inadequate treatment of these conditions which could result in infertility and chronic pain. Perhaps even more serious is the perpetuation of mycoplasma resistance which may result in a serious public health crisis in the future. In the not too distant past there would been no hesitancy in introducing Mycoplasma testing appropriately. It is the right thing to do for now and the long-term but we are paralysed by our current financial situation.

Whilst I and my colleagues have been grappling with righting tenders and managing reducing budgets, we have not only been diverted from clinical work but also from innovation and clinical research.

Sexual health services in the UK have been respected throughout the world for our excellence of care, research, innovation, and antimicrobial stewardship. This reputation is at peril as fewer are attracted to our, until recently, over-subscribed speciality and those working in the specialty are stretched by underfunding and lack capacity to maintain activity in research and innovation.

**De-commissioning of non-core services**
The focus of local government is on health promotion and prevention. The bulk of what the Trust does is the diagnosis and treatment of conditions related to sexual health (sometimes STI related, sometimes not). In the context of a reducing budget and in line with the quite narrow national public health outcome framework targets, the focus of the new service specification is testing for Sexually Transmitted Infections (STIs), prevention and treatment, preventing unwanted pregnancy in <25s.

This can narrow a trust’s service offer unless other commissioners recognise this and find extra money (money they may well have lost to local government when the commissioning budgets were split. Issues such as sexual dysfunction, vulval dermatology, psychosexual issues, genital pain syndromes, recurrent genital discharge (non STI related), contraception to >25s. Currently the trusts are best placed and most skilled to manage these patients locally. If we need to restrict access and triage back to primary care, there is no evidence-based triage strategy that is effective at picking out STI from non-STI presentation. Hence there is a real risk of delaying access to STI diagnosis with associated increased risk of complications and onward spread of infection and increased cost. GPs neither have the expertise nor the capacity to manage these patients and patient care will be likely be compromised if no-one can will pay for them in secondary care.

Workforce:

I work with a fantastic and committed team who strive to provide the best care for patients. Sexual health is not a speciality one enters if they are seeking glamour, prestige or financial reward.

We see a diverse range of people, with a disproportionate representation of the vulnerable and those who are less socially and economically privileged. We are trained to ask the sensitive questions well and we frequently engage in conversations with patients around very difficult aspects of their lives and relationships.

We take pride in the holistic care we can offer and the positive outcomes we can achieve for our patients. To demonstrate the complexity of patients that we see I have described a few case scenarios below. Current commissioning aims to simplify our responses to these complex presentations. There is deep dissatisfaction associated with this both for the patient and the clinician.

Staff are working at maximum capacity, and stress levels are high. Uncertainty about the future compounds this sense of dissatisfaction.

Recruitment across the country is becoming difficult. We were until recently an oversubscribed speciality but recent rounds of specialist registrar recruitment nationally were greatly undersubscribed.

Case Scenarios

The following are typical presentations that we see on a daily basis in our service. I hope that they illustrate the complexity and importance of our work. In addition, I hope they demonstrate the potential difficulties in funding isolated aspects of sexual health and that a simplified commissioning system with protected budgets is needed.

Case 1:
Anna, a 16-year-old female from Plymouth presents to the sexual health service. She has been contacted by one of our health advisors as she has been named as a contact of chlamydia. She admits to lower abdominal pain and discharge. She is not taking regular contraception and had unprotected sex 3 days previously. She is using illicit drugs. Her current partner is 19 and they met online. She admits that she does not always want to have sex but does anyhow as she feels it is expected of her. Her boyfriend is providing her with drugs and alcohol. On further enquiry she admits to being forced to have sex at 14 years of age. She currently is not engaged in any other services.

Actions: Anna is diagnosed clinically with pelvic inflammatory disease following a through history, physical examination and review of slides of vaginal fluid under the microscope. She is treated with a 2-week course of antibiotics and tests are sent to the laboratory for chlamydia, gonorrhoea, HIV and Syphilis. Anna is advised that she is at risk of pregnancy, a pregnancy test is negative, she is prescribed emergency contraception (after declining and emergency IUD). An implant is inserted on the day to provide ongoing contraception. Anna is referred to the health advisor in clinic for a further discussion around her drug use, historical non-consensual sex and possible coercion within the current relationship. She is offered immediate support and advice. She is referred to drugs and alcohol services. More information is collected about her current relationship and this is discussed at our departmental safeguarding meeting. A decision is made at that meeting to make a safeguarding referral as there were significant concerns around exploitation.

Anna is followed up after 2 weeks to ensure symptoms have resolved, repeat pregnancy test and discuss safeguarding referral. She is offered an appointment with a psychologist to discuss her historical sexual assault and explore its link with current risk-taking behaviours.

Case 2

Mary is a 65-year-old female who presents to our walk-in service. She is a widow and has recently met a new partner. She presents as she is concerned that sex with this new partner was very painful. She has also been self-prescribing for thrush with over the counter Canesten which she has been doing intermittently for years. She has not discussed this with her GP as it is ‘too embarrassing and I can’t get an appointment anyway’. She went through the menopause 15 years earlier. Mary was examined and found to have skin changes consistent with lichen sclerosis, a chronic inflammatory skin condition which results in irreversible scarring and secondary pain. It is associated with vulval cancer if not treated adequately. A vaginal swab was taken and examined under the microscope which demonstrated an atrophic vaginal epithelium which could also be contributing to painful sex.

A full STI screen was sent, Mary was prescribed topical potent steroids and emollients and educated on management of Lichen sclerosis. She was prescribed local vaginal oestrogen to reverse atrophy and enhance lubrication. She was advised on simple techniques to reduce discomfort during sex and we had a conversation about her vulnerabilities within this new relationship (her first new relationship in 40 years!).

Case 3

John is a 21-year-old man who identifies as gay. He is not in a regular relationship. He has never been to a sexual health clinic before. He is having frequent unprotected sex with casual partners he meets on dating apps. He does not use condoms consistently. His last had unprotected receptive anal sex 2 days ago with a casual partner. He has never been vaccinated against Hepatitis A/ B.
He attends clinic as he is concerned about a lump in his testicle. He is not too concerned about his risk of STIs. On examination he has a unilateral painless epididymal lump consistent with a simple cyst. John is offered a full STI screen including throat, rectal and urine samples for chlamydia and gonorrhoea and blood tests for HIV, Syphilis and Hepatitis A and B. A point of are test is negative for HIV. Following discussion about risks and benefits he is started on post exposure prophylaxis against HIV (28-day course of anti retrovirals) He is offered vaccination against hepatitis A and B and offered information about future availability of HPV vaccination.

John has a positive test result for rectal chlamydia, it is negative for LGV. He is invited back to clinic and given treatment with doxycycline. Sexual contacts are explored and John gives permission for the clinic health advisor to contact known contacts to invite for testing and treatment. Further discussion is had around risk behaviour and supports such as motivational interviewing were offered. John is not interested in changing behaviour right now as he is happy. Future risk of HIV is discussed and the role of pre-exposure prophylaxis against HIV (PrEP). He is invited onto the IMPACT study. John will come back to clinic to discuss after completing PEP.

Thank you for listening

October 2018