Written evidence from Dr Janet Wilson

Submitted by Dr Janet Wilson, Consultant in Sexual Health and HIV, Leeds Teaching Hospitals NHS Trust. I am submitting the evidence as an individual, however I have been a Consultant in Sexual Health for 30 years. I have also been a Past-Chair of the Specialist Advisory Committee in Genitourinary Medicine and a Past-President of the British Association for Sexual Health and HIV.

Summary
Sexual health services are unable to cope with the increasing demand. STI rates are equivalent to those of World War II and babies with congenital syphilis are being born to UK-born women who are acquiring syphilis during pregnancy.

The Health and Social Care Act has fragmented sexual health services and destabilised some HIV services.

Repeated short term sexual health tendering has led to a reduction in experienced clinicians, diverted money away from patient care, and de vested morale in the sexual health workforce. It has stifled any innovation and long-term planning of services and essential service developments have been unable to be implemented.

Sexual health services have been poor in the past and it may be useful to consider, and learn from, how they were improved.

Recent trends
I have the advantage of having worked in sexual health services since 1984 so have experienced a similar situation to the one at present in the early to mid-2000s. I have included some history of this and the solutions as these may be helpful for the current situation.

Following the 1987 ‘Don’t die of Ignorance’ campaign about HIV/AIDS, STIs dropped to an all-time low. Highly active antiretroviral therapy became available in the late 1990s and changed HIV from a terminal condition to a chronic infection. STI rates began to rise from the late 1990s onwards. Infections rarely seen, such as syphilis and lymphogranuloma venereum, began to re-emerge. The increased demand for sexual health services resulted in queues to get into walk-in services and long waits to get appointments. In 2001 the National Strategy for Sexual Health and HIV was published by the Department of Health with money allocated to help sexual health services. Unfortunately the allocated money did not reach sexual health services as it was kept by the Primary Care Trusts to help balance their overspends. In 2004, the Department of Health published Choosing Health – Making Healthy Choices Easier, which committed new capital and revenue funding to tackle the high rate of STIs in England. It also stated that the NHS should offer the same fast access to high quality GUM services that people expect of other NHS treatment. The goal was that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours – a target that was only currently met for 38% of attendances.

The rate of GUM clinic appointments within 48 hours rose slightly but was still only about 55% at the beginning of 2006. Access to GUM clinics was included in The NHS in England: the operating framework for 2006/7; ‘to deliver the Local Delivery Plans trajectories so that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours’. This ensured that the Choosing Health money was invested in sexual health services so that Trusts could achieve this NHS target. Payment by Results (PbR) tariffs were also introduced and these ensured clinics got paid for the work they had delivered. The
target of 98% of people being offered an appointment within 48 hours was achieved in England by March 2008 as shown in Figure 1.

As someone who had been working in sexual health for 24 years, in 2008 the quality of sexual health services was the best they had ever been in my career. The rates of STIs stabilised over the next few years confirming that the financial investment and the mandatory target had brought about an improvement in sexual health services. Even with the budgetary cuts that were needed from 2009 onwards, the number of sexual health screens and HIV tests continued to rise indicating improved productivity.
The Department of Health’s ‘Improving outcomes and supporting Transparency’, in 2012, dropped the 48 hours access target in favour of the public health outcomes of chlamydia diagnosis rates and percentage of people presenting with late HIV. GUM PbR tariffs were not developed further in view of the Health and Social Care Bill enactment from April 2013 meaning that sexual health was no longer part of the NHS.

Between 2008 and 2017 the reported cases of early syphilis have increased by 148% (these are at the levels seen during the Second World War and we are seeing cases of congenital syphilis) and the cases of gonorrhoea have increased by 198%.

**Funding**

After an decade of public spending cuts, the £20bn funding boost to the NHS is very welcome. However, no such funding has been promised to public health. The public health grant that the Department of Health and Social Care gives to Local Authorities is due to fall from £2.44bn this year to £2.27bn in 2019-20. This will be the fifth year of cuts since the peak of £2.86bn in 2014-15. In 2019-20, sexual health services will be getting 25% less than in 2014-15.

With the severe budgetary restrictions faced by Local Authorities it is not surprising that sexual health cuts have been mainly implemented by tendering services using block contracts of about 3 years which are for less money than the previous service. However, the reduced budget is not nearly as damaging to a sexual health service as the process of repeated rounds the tendering. The process of putting the tender document together takes senior clinicians and managers away from clinical care meaning that money is diverted from patient care. The short term contracts stifle all long term planning and innovation.

**Co-commissioned services**

Many sexual health services are no longer collocated with the HIV service. This has reduced the access to sexual health services for those living with HIV. The tendering of sexual health services has destabilised some HIV services when the local Hospital Trust did not win the sexual health tender meaning the HIV service alone was not financially viable for the hospital Trust. Mid Yorks Trust is an example of this and the HIV service is now provided by Leeds.

There is inequality within the UK with no commissioned PrEP service in England as opposed to Scotland and Wales. Some non-NHS provided sexual health services have been unable to participate in the PrEP Impact Trial due to not having the appropriate NHS research support and governance. In West Yorkshire, with a population of 2.2 million people, there are just two clinics in Leeds and Halifax taking part in the PrEP Impact Trial as all the others are non-NHS providers.
The reduced budgets mean that there is no funding for new service developments. For instance, it is now recognised that *Mycoplasma genitalium* is a common STI and our current antibiotic prescribing is increasing *M. genitalium* resistance. Indeed it is thought that *M. genitalium* may become the first untreatable STI rather than gonorrhoea. It is widely agreed that testing (including resistance testing) for *M. genitalium* is important but how will this be funded in our current situation?

**Workforce Issues**

The reduced budgets have led to sexual health services to have to make workforce reductions. For instance, in Leeds when the sexual health services were tendered we had to lose two Registrar posts and 0.4 whole time equivalent of a consultant post to fit within the budget. Some providers are either not advertising consultant vacancies, or advertising them as locum posts rather than substantive posts, or advertising them at less than full time, because of the uncertainty of their future budgets. This is despite the increasing complexity of the medical conditions presenting to sexual health services.

The tendering process is unsettling for all staff as they are unsure who their next employer might be and whether or not their job will be secure. This has a negative impact on staff morale and leads to an unhappy workforce with problems with retention and recruitment.

**Action to improve sexual health**

Sexual health services been poor in the recent past. Access only improved when a mandatory 48-hour access target meant that money was given directly to sexual health services and tariff based payments ensured clinics got paid for the work they had delivered.

Would the introduction of this solve all our problems now? Sadly I don’t think so. The repeated rounds of tendering would continue to have a destabilising and negative effect on our services and workforce. How can a clinical specialty that takes a minimum of 8 years to train a consultant, and several years to train a Clinical Nurse Specialist, function, prosper and progress on the basis of just 3-yearly contracts?

My belief is that the best solution is for sexual health services to be taken back into the NHS and linked again with HIV care.