1. Homerton Sexual Health Services (HSHS) welcome the opportunity to give evidence to the Health and Social Care Committee. Our perspective is that of an inner city, expert NHS agency for all aspects of advice, diagnosis, treatment, care, prevention, training and research for sexual health, reproductive health, sexually transmitted infections and HIV. HSHS delivers both open-access and referral services locally, London-wide and nationally. The department has particular expertise in working with diverse, vulnerable and marginalised communities to secure best outcomes.

2. HSHS is a department of Homerton University Hospital NHS Foundation Trust, operating from 4 bases across the London Borough of Hackney and the City of London, together with outreach venues. HSHS multidisciplinary teams contain health professionals (for both physical and mental health), specialists in social care, peer supporters, prevention specialists, administrative and management staff alongside collaborations with other NHS, academic and NGO providers, locally and nationally.

Background and Context

3. The population of Hackney is younger, more mobile than the England average and is hyper-diverse, with a mix of White British (36.2%), Black African (11.4%) Black Caribbean (7.8%) Turkish (4.8%) and Asian (3.1%) communities as well as mixed ethnic backgrounds. There is considerable inward migration, with 39.1% born outside of the UK. Levels of social disadvantage are high - 33% of Hackney households experience multiple deprivation. Rates of poor mental health are above the national average.

4. STI rates in Hackney are amongst the highest in London, which are in turn the highest in England. In 2016 new STI infection rates in Hackney were 2,524.8 per 100,000 residents, the third highest of any London borough. This is almost double the average rate for London (1,335 diagnoses per 100,000 population) and almost four times that of the UK average of 795 per 100,000 residents. There is significant inequality in the rates of poor sexual health, with black and ethnic minority populations in the borough and those with high deprivation scores shoudering the greatest burden of new STI diagnoses.

5. HSHS sees and treats ever-increasing numbers of patients, rising from 39,027 in 2013 to 50,724 in 2017. The total number of services/interventions delivered rose from 53,683 in 2013 to 98,108 in 2017. The numbers of people with gonorrhoea has doubled in that time and the numbers of cases of syphilis has risen by 450%. Reinfection rates with a new STI, a marker of persistently risky behaviour, are also consistently higher in Hackney than the national average.

6. Our HSHS working environment is characterised by unrelenting and disconnected change across multiple areas of policy and practice coupled with inadequate and falling funding and an ever-increasing demand for care. Our response highlights what we see as some key themes within sexual health reproductive health and HIV, illustrated with local examples of their impact.
Strategy and leadership

7. There is no national strategy for sexual health, reproductive health and HIV. This is keenly felt at a time when multiple national and local policies, all operating in apparently complete isolation one from another, have consequences for sexual health and HIV. The Health and Social Care Act (2012), the austerity agenda of the Treasury, the hostile environment created by the Home Office and the Brexit negotiations all influence the local picture for sexual health and HIV. The current policy emphasis on localism and devolution result in significant variability in the prioritisation of sexual health within and between local geographies.

8. There is a leadership vacuum. The implementation of the Health and Social Care act (2012) saw the transfer of responsibility for public health, including sexual health, from the NHS to local government. At the same time new organisations with crucial roles to play in sexual health and HIV - NHS England, Public Health England, Health Education England and Clinical Commissioning Groups – have been established. Best outcomes require whole system approaches and the relevant leadership to deliver. At the local level, leadership, where it can even be identified, is devolved and distributed and lines of accountability blurred. STPs – a mechanism for joined up placed based approaches have thus far not engaged with sexual health and HIV.

9. Success is possible - proof of concept. HSHS example: falling rates of new HIV diagnoses amongst men who have sex with men. The steep fall in new HIV infections reported by five London clinics including HSHS is a shining example of the power of joined up whole system working, often outside existing commissioning and funding arrangements and despite their constraints. Facilitated by bold and sometimes disruptive leadership, outcomes represent the combined efforts of high rates of testing / repeat testing, rapid initiation of antiretroviral therapy for those diagnosed HIV positive, access to PrEP through research (the IMPACT trial) for those diagnosed HIV negative, community activism to source affordable PrEP outside statutory services and clinical trials (Pepster, Iwantprepnow) the provision of clinical monitoring and support for PrEP users by clinicians, best practice guidance from professional bodies, coupled with experiential expertise and peer support from NGOs. A glimpse of a future where new HIV infections could become a thing of the past.

Commissioning arrangements and their impact

10. The commissioning responsibilities for the SH, RH and H pathways are now split between multiple bodies. The impact for HSHS is a lack of clarity and confusion about roles and responsibilities, leading to gaps in what were previously robust pathways of commissioning and care delivery. The complexity of the current system coupled with inadequate funding actively hinders our ability to deliver appropriate integrated responses to the changing epidemic of poor sexual health and to the needs of the people seeking effective care.

11. HSHS EXAMPLE: Falling rates of cervical screening. The national cervical screening programme is a responsibility of NHS England through section 7A. It is well documented that there are higher rates of cervical pathology identified in those women who attend sexual health services when compared to those attending GP services with a 70% higher rate of CIN 2/3 when compared to general practice SH services reach a different population of potentially more vulnerable women. Confusion about funding mechanisms and responsibilities for cervical screening led to a reduction in activity of over 75% in 2016 after explicit direction from NHSE and the LA to reduce access. Importantly women who no longer
attend HSHS for cervical screening are not reappearing elsewhere evidenced by significant drop year on year in screening coverage rates.

12. **HSHS EXAMPLE: HIV seroconversion in people who have tried to access PrEP.** Divorcing the responsibility for prevention of HIV (mostly local government) from the responsibility for HIV treatment and care (NHS England Specialist Commissioning) has undermined best use of highly effective approaches to HIV prevention. Legal intervention was required to clarify commissioning responsibilities. HSHS is a trial site for both the PROUD study to demonstrate the efficacy of PrEP and now the IMPACT study of implementation approaches. Our allocation of spaces on the IMPACT study was filled within weeks of the trial opening. Highly vulnerable people have been unable to access PrEP either within our service at HSHS or elsewhere. We are currently seeing people who have been unable to access PrEP present with what is completely preventable acute HIV seroconversion. This is unacceptable – for patients, service providers, for public health and increases costs across the health economy.

13. **HSHS EXAMPLE: Mental Health services and care.** Psychosexual services are now commissioned separately (CCGs) from sexual health (Local government). Despite high levels of demand and even with appropriately skilled mental health professionals in the sexual health team care is not provided unless CCG commissioned, thus leaving people without alternative sources of care. HSHS has developed a business case that has been accepted by the local CCG and are now able to deliver a limited capacity psychosexual service.

14. The HSHS clinical psychology team are no longer commissioned to provide mental health care for people who have experienced sexual trauma. Such patients are now expected to access the Haven or alternatively primary or secondary care mental health services. However, in Hackney primary care psychology do not accept referrals for complex trauma and secondary care mental health services have a 21-month waiting list for individual therapy. This leaves some of the most vulnerable people in our service without appropriate care.

15. **HSHS EXAMPLE: Clinical Nurse specialists for HIV.** HSHS employs two community-based HIV clinical nurse specialists (CNS) who provide a vital link to specialist services for complex, vulnerable patients with complicated psychosocial and medical issues. These patients frequently have multi-morbidity and the service strives to provide integrated care for these individuals who might otherwise not only disengage from HIV care, but also face challenges in making best use of other health and social care services. The community CNS service mitigates poorer clinical outcomes and unplanned service use by linking people to services and co-ordinating the care delivered.\textsuperscript{xiv}

16. The commissioning responsibility for this service has however, fallen into the “cracks” in the new arrangements under the Health and Social Care Act. NHS England has been clear that they are not the responsible commissioner, despite the service being integral to the delivery of HIV treatment and care in Hackney. At the time of transition, the budgets for these services in England were transferred in an unplanned fashion to either Local Authorities or CCGs. In Hackney, the budget was transferred to the Local Authority, but without a commissioning remit or contract. Thus, as financial constraints bite, the future of this service is under threat, with the risk of a severe impact on the clinical care of people living with HIV, but without involvement of the commissioners of specialist HIV care.
17. **HSHS Example: Reduction in services for sex workers.** Sex worker services across London have been decommissioned. In East London, the Open Doors project successfully delivered health and social care to sex workers in Hackney, Newham and Tower Hamlets. This was fragmented as part of the pan-London sexual health transformation project, with some of the functions being absorbed into the general sexual health contract and some being stopped completely. Those that continue have faced budget cuts of over 40%, fragmentation of services and funding instability making it extremely challenging to plan and deliver an effective service. This coincides with instability in the delivery and commissioning of associated organisations such as addiction services. The support networks are extremely difficult to replicate once disrupted. This has left a group of extremely disadvantaged individuals with significant personal and public health issues without appropriate support.

**Ways of Working**

18. The transfer of responsibility for sexual health, HIV prevention and some aspects of reproductive health from the NHS to local government has required substantial changes by HSHS in our ways of working. Local authority contracting, and procurement arrangements differ significantly from those within the NHS. The culture of Local Government and the NHS differ. There has been a steep learning curve for all involved in both organisations which has taken time and energy and deflected attention away from sexual health.

19. **HSHS Example: Ways of working.** The financial and accounting processes for NHS England funded care and Local government funded care are significantly different, yet within HSHS the same staff in the same building are delivering both services simultaneously, sometimes within a single episode of care. Differentiating activity, allocating various tariffs to different work streams, different requirements for monitoring performance have added a significant administrative burden which has been met from within existing resources including the time of some of the most experienced clinicians, taking them away from front line patient care.

**Epidemic Control**

20. Responses to outbreaks of sexually transmitted infectious that do not respect geographical boundaries are harder to tackle when each local authority has unilateral control.

21. **HSHS Example: Syphilis in HSHS and across London.** New syphilis infections have risen by 450% in the past 4 years at HSHS. Syphilis is concentrated in urban areas with a high MSM population and we are witnessing a very worrying upsurge in syphilis among MSM across London. Yet there is no mechanism for a pan London approach to epidemic control, with each local authority taking its own approach. Neither the pathogen nor the patients can be confined within borough boundaries. Unlike for example, flu vaccination, there is no mechanism to harness expertise in syphilis control centrally to make a difference or to secure financial economies of scale.

**Funding**

22. Although NHS funding has been relatively protected this is not the case for local authority public health budgets, which have been radically reduced, with a 7% cut in 2015 – 16\textsuperscript{v} and a further 3.9% reduction year on year. This means that cost saving exercises have been forced
upon local authorities with a disproportionately high toll for sexual health services\textsuperscript{xxi, xxii} and patient care in some parts of the country has suffered as a result\textsuperscript{xxvii}. The BMA recently concluded that sexual health services are under-resourced with the result that current service design is driven not by innovation or need, but by cost\textsuperscript{xxix}

23. Many local authorities have initiated procurement exercises for sexual health services. Although such an exercise could and indeed should be a vehicle for innovative development and improvement, lack of investment means that innovation has largely been confined to finding ways to save money. Recent communication from Local Government Association makes it clear that there is now no room for any further efficiency savings in the face of increasing demand.\textsuperscript{xx} These enormously burdensome processes have resulted in major service reconfiguration, alterations in service specifications, have put previously collaborating clinical teams into direct competition, damaged some excellent working relationships and disrupted established geographical networking arrangements. At a time when the need for joined up collaborative approaches to tackling rising rates of poor sexual health have never been greater many teams have been mired in writing bids and dealing with contract negotiations.

24. **HSHS EXAMPLE: HSHS tender exercise and service redesign.** HSHS has recently been the successful bidder in a procurement exercise to deliver sexual health services to Hackney and the City of London. The contract has been awarded with reduced funding. Developing the bid was a huge workload for the senior clinical team which was additional to the clinical “day job”. HSHS was in direct competition with Barts Health and previously excellent working relationships across the two services were seriously damaged by the process. Implementation of the bid has taken up all administrative and management capacity within the HSHS department, which has in turn impacted on the support available for the NHS England funded HIV service which is co located and co provided. The service sees ever-increasing numbers of people seeking care.

25. **HSHS EXAMPLE Introducing new investigations – e.g. Mycoplasma testing** New national professional guidance will recommend additional tests for Mycoplasma genitalium, a recently recognised cause of sexual ill health. Without allocation of a tariff/code this will not be affordable for HSHS. The test is currently expensive (£35 approx. each), laborious (done off site) and has slow turnaround.

26. **HSHS EXAMPLE Costs of tackling syphilis epidemic.** Measures to tackle the upsurge in syphilis infections consist of resource-intense work, for example increased testing frequency, reduced test-to-treat interval and better diagnostics. Point-of-care testing is confined to dark ground microscopy the introduction of a sensitive test that includes treponemal PCR would improve diagnostic and treatment rates, however this is currently unaffordable (£86/test).

27. **HSHS EXAMPLE Potential Costs of multi-resistant gonorrhoea.** Given the very high rates of gonorrhoea seen within HSHS this nationally emerging problem is one for which we must be prepared. It represents a potentially very expensive condition which will require additional staff resources, laboratory expertise, delivery and costs of alternative treatments, focussed contact tracing etc. There is no financial contingency for these costs within the existing system.

28. **Austerity** is having a direct impact on the lives of our local population and our patients through cuts to other services such as housing and financial support undermining health and wellbeing. Funding is being withdrawn from many NGOs that support people living with or at risk of HIV and poor sexual health\textsuperscript{xxxi}. The policy of creating a” hostile environment “to
deter inward migration has caused considerable hardship and suffering to people already living here who are HSHS patients.

Workforce

29. Health Education England has recently undertaken a review of the sexual health, reproductive health and HIV workforce, noting the confusion in responsibilities applies to workforce planning, workforce sustainability and the education and training elements. A report from the Royal College of Nursing described falling numbers of nurses choosing to work in sexual health and HIV.

30. **HSHS EXAMPLE** at Homerton we have found it very difficult to recruit to our nursing posts due to a lack of applicants in the system. There is evidence that fewer doctors are choosing a career in GU medicine due to the structural and funding issues- in HSHS fewer doctors are in training and gaps within our workforce impact negatively on service delivery. HSHS has a very diverse workforce and the impact of Brexit has led several senior European clinicians to leave the UK. At the same time workforce in primary care is under huge pressure which in turn impacts on sexual health and contraception provision. Women are have increasing difficulty accessing effective and acceptable contraceptive methods particularly long acting methods, unwanted pregnancy and the rate of abortion is increasing particularly in younger women.

31. Specialist clinical psychologists embedded within the HSHS clinic work with people who have particularly complex needs or with high risk behaviours including chemsex and with people who are vulnerable to sexual exploitation. It has been difficult to recruit and retain staff within this role because of the high level of complexity that must be managed alongside the lack of local onward referral options.

Recommendations

32. The local authority public health grant must be restored and increased to enable the commissioning of comprehensive open access sexual health services that meet existing needs and deliver best outcomes for individuals and for populations. This funding should continue to be ring fenced.

33. There is an urgent need for a national strategy for sexual health, reproductive health and HIV which is adequately funded and implemented.

34. The commissioning bodies need to work more effectively together, collaborating and coordinating across the whole system including clinicians and service users, taking an outcomes-based approach.

35. Develop system leadership across SH RH and H to allow expert clinicians, public health teams, primary care, NGOs, patients and commissioners to work effectively together.
36. Develop ways to better use existing mechanisms for integrated working such as STPs and ACOs

37. We urge NHS England and Local Authorities to commission a national PrEP programme as soon as possible to avoid ongoing preventable HIV acquisition.

October 2018

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