

Advancing our Health: Prevention in the 2020's Consultation

Submission by the British Association for Sexual Health and HIV (BASHH)

October 2019

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The British Association for Sexual Health and HIV (BASHH) is the lead professional representative body for those managing sexually transmitted infections (STIs) and HIV in the UK. It has a prime role in education and training, in determining, monitoring and maintaining standards of governance in sexual health and HIV care. BASHH also works to further the advancement of public health in relation to STIs, HIV and other sexual health problems and acts as a champion in promoting good sexual health and providing education to the public.

EXECUTIVE SUMMARY

BASHH welcomes this consultation from the Department of Health and Social Care and the ambition to achieve 'parity of esteem' for treatment and prevention-based approaches for health in this country. As highlighted within the consultation, high-quality sexual health services and good sexual health outcomes are a core aspect of prevention and should be seen as a key part of the puzzle in terms of how we work towards improving the health and wellbeing of the nation.

With this in mind, BASHH believe that it is imperative that a new sexual health strategy is taken forward as soon as possible. The development of a new sexual health strategy will help to address the challenges that the sector is currently facing and will facilitate an increased focus on sector-led improvement, within a changing NHS operating environment.

BASHH believes that the following key areas must be prioritised within the development of a future sexual health strategy:

1. Highlighting the need for increased sexual health funding to reverse the persistent cuts that have impacted upon the delivery of services in recent years. Funding must reflect population need and allow for the capacity to respond to change and invest in future development and planning.
2. Setting out a framework that can deliver a more joined-up approach to the *structure* of sexual health service commissioning, reducing existing fragmentation and facilitating increased co-commissioning between the NHS and local government.
3. Embedding a more progressive approach to the *process* of sexual health service commissioning. In the first instance, this should include moving away from the mandatory tendering of contracts when sexual health services are commissioned, towards instead an approach which embraces regular and constructive review without leading to destabilisation. This would help provide stability and improve recruitment to the speciality. When tendering does take place, local areas should be encouraged to implement longer contracts, to help facilitate better strategic planning and to mitigate the disruption and burden on the workforce that shorter-term contracts can produce.

BASHH also believes that the development of the sexual health strategy must be shaped directly by expert clinicians and commissioners and others with direct expertise in the delivery of frontline sexual health care. The process should be prompt, efficient and streamlined to ensure an effective strategy is implemented without delay.

KEY PRIORITIES FOR A SEXUAL HEALTH STRATEGY

BASHH welcomes the development of a new national sexual health strategy, the introduction of which will come at a critical time in light of the challenges currently facing the sector. BASHH has been working closely with key partner organisations to advocate for a strategy to be taken forward, including sharing extensive written and oral evidence with the Health and Social Care Committee, who positioned the development of a strategy as the key recommendation from their recent inquiry into sexual health.

As suggested in this current consultation on the contents of the Prevention Green Paper, BASHH has identified three key areas which we feel must represent clear priorities to be included within a future sexual health strategy.

Priority 1: Ensuring sufficient funding for sexual health

Pressures on sexual health and the services that provide vital care for those in need have increased considerably in recent years. Unfortunately, in tandem with these increased pressures, recent years have also seen the delivery of persistent and damaging cuts to sexual health budgets, as part of reductions in Government funding for the wider public health grant, from which they are funded. A mismatch between demand and the resources in place to meet it inevitably has consequences, as detailed below.

Since the transfer of sexual health commissioning responsibilities from the NHS to local government in 2013, attendances at sexual health services in England have increased by 21%, from 2.9 million in 2013 to 3.56 million in 2018.¹ Alongside this, and as highlighted within the Prevention Green Paper, there has also been a significant increase in the number of newly diagnosed sexually transmitted infections (STIs) in this country.

Latest data from Public Health England (PHE) shows that overall rates of STIs have increased by 5% in the past year, reaching 447,694 in 2018.¹ This included 56,259 new diagnoses of gonorrhoea, representing a rise of 26% compared to the previous year, as well as 7,541 cases of syphilis, representing a rise of 5%. Cases of syphilis are now at levels not seen since World War Two.¹

Of particular concern is the fact that these significant increases in STI diagnoses have coincided with the spread of antibiotic resistant infection. 2018 saw the first globally reported case of multi-drug resistant gonorrhoea in England, which follows an initial outbreak of high-level azithromycin resistant gonorrhoea in England in 2015, and subsequent outbreaks across the country in 2016 and 2017.

Recent years have also seen increased resistance in the STI mycoplasma genitalium (Mgen), a relatively newly discovered infection which has been wrongly diagnosed as chlamydia in many cases. Whilst the STI can be easily diagnosed through a simple diagnostic nucleic acid amplification test, a recent BASHH survey of public health commissioners found that only 10% of public health commissioners were planning to provide funding for Mgen testing. 72% of BASHH experts said that if current practices do not change, Mgen will become a superbug, resistant to 1st and 2nd line antibiotics, within a decade.²

¹ PHE. Sexually transmitted infections and screening for chlamydia in England. June 2019 Available online at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>

² British Association for Sexual Health and HIV. July 2018. Available online at: <https://www.bashh.org/news/news/bashh-launches-new-nice-accredited-guidelines-to-help-prevent-mycoplasma-genitalium-becoming-the-next-superbug-but-funding-cuts-may-hinder-implementation/>

Sexual health services have unfortunately been required to tackle these pressures amidst a backdrop of persistent and damaging cuts to their available resources. Despite recent commitments from the Government around increasing 'NHS' funding, the public health budget has regrettably not received similar treatment, instead being subjected to multiple cuts, including several particularly damaging 'in year' cuts. Overall sexual health service funding has fallen in real-terms by 14% between 2013/14 and 2017/18, including cuts of 35% to the budgets allocated to sexual health advice, prevention and promotion services across the country.³

These cuts have had a direct and detrimental impact on sexual health service funding and the subsequent ability to carry out core functions, leading the Local Government Association (LGA) to describe the sector as 'at tipping point'.⁴ The situation has also been exacerbated by the continued uncertainty around the future of the public health ring-fence grant and the mechanism through which it is funded. Proposals to move towards a system by which public health budgets are funded through local business rate retention, and the removal of a 'ring-fence' as part of this, would be deeply damaging and we strongly oppose this. Such a system would likely lead to regional funding disparities, posing significant risk for sexual health services, prohibiting longer-term planning, whilst also threatening to worsen sexual health inequalities in the process.

Sexual health services have a strong track record in innovation, of implementing efficiencies, embracing new technologies and new ways of working. Services have merged, collaborated, gone online, but ultimately there is a limit to what can be achieved without adequate resource. Doing 'more for less' eventually just becomes doing less. Public health is an area to invest to save and it's counterproductive to do otherwise.

Therefore, and as highlighted by the Health and Social Care Committee, sexual health funding cuts represent a false economy and are actively putting people's sexual health at risk. Cuts have fallen particularly heavily in the area of sexual health prevention, jeopardising early, effective intervention and increasing overall costs for the NHS.

It is essential that recent funding cuts are reversed and the sexual health strategy is accompanied by sustainable and long-term funding for the sector.

Priority 2: Achieving effective sexual health co-commissioning

The Prevention Green Paper highlights the opportunity to achieve greater co-commissioning of integrated sexual health services, the delivery of which should represent a key priority within the sexual health strategy.

The transfer of public health commissioning responsibilities in 2013 through the Health and Social Care Act led to a complex and ultimately fragmented approach to sexual health commissioning and service delivery in England. Whilst STI prevention, testing and management, HIV prevention and diagnosis and contraception provision and management sat under the responsibility of local authorities, NHS England assumed the responsibility for the commissioning of cervical screening, HIV treatment and care, whilst Clinical Commissioning Groups (CCGs) were made responsible for commissioning community gynaecology, genital dermatology and psychosexual health services.

On the whole, this arrangement has increased fragmentation and complicated service delivery. Significantly, it has also blurred the lines of accountability for when problems emerge in the system. It has also had a negative impact on workforce planning, training and staff development. As recognised by the Health and Social Care Committee, this situation has not only had a clear and detrimental effect on those working in the sector, but also jeopardises the 'pipeline' of future specialists in sexual health.

³ Health Select Committee. Sexual Health Inquiry. 2019. Available online at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>

⁴ Local Government Association. August 2017. Available online at: <https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils>

To help remedy this situation, the sexual health strategy must set the framework for achieving a truly joined-up approach to sexual health commissioning, more effectively integrating local government and what is defined as 'the NHS', between which there is currently a false distinction. Achieving this will help embed a progressive and prevention-based approach to sexual health within emerging models of care (such as Integrated Care Systems).

The sexual health strategy must prioritise giving clarity to what co-commissioning arrangements for sexual health should look like, including ensuring that sufficient safeguards are put in place and accountability between different organisations is clearly set out.

Priority 3: Embedding a more progressive approach to sexual health commissioning

The introduction of the Health and Social Care Act 2012 has resulted in sexual health services being subjected to competitive local authority tendering processes. Whilst tendering represents 'normal' local authority practice and it is reasonable to expect that services are delivered in a cost-effective and efficient manner, the way in which some tenders are currently carried out can have a disproportionately disruptive impact on services and the staff working within them. When sexual health service commissioning is put out to tender, this often results in clinical staff needing to divert significant amounts of time away from service delivery and care, towards delivering tender submissions instead, in an environment where clinics are already worryingly under-resourced.

In light of this, and as part of the move to introduce more joined-up, co-commissioned sexual health services between the NHS and local government, the strategy should support a move away from the mandatory tendering of contracts when sexual health commissioning takes place. There should instead be much more scope for flexibility on the approach to tendering, taking into account existing local arrangements and need.

The strategy should also encourage the introduction of longer-term contracts for when tendering of services is felt necessary. At present, many tenders introduce short-term service contracts which can see the process repeated every three years, exacerbating the burden placed upon the workforce and destabilising services as a result, particularly as rival bidders are less likely to sustain meaningfully collaborative networks and joint working.

The challenges caused by the current approach to commissioning and tendering appears to have contributed to significant concerns raised by those working in the specialty about the future of the sector. Results from the most recent BASHH member survey found that 81% of respondents felt that staff morale had decreased within their service, with many respondents specifically identifying the burden and disruption created by service tenders as a key reason for this.

More than 9 in 10 respondents to the survey (92%) meanwhile described themselves as being worried or extremely worried about the future delivery of sexual health care in England under the current commissioning and service tendering environment. These concerns and wider pressures have seen many experienced, specialist clinicians leave the sector in recent years, and they have also had a knock-on impact on the enthusiasm of potential new recruits joining the sector, demonstrated by the worrying increase in the number of trainee posts remaining unfilled. Ultimately, sector de-stabilisation and consequent inability to see a long-term, secure future for professionals in the specialty, allied to ongoing threats to training, education and professional development have all contributed to extremely concerning recruitment rates

Embedding a more progressive approach to the process of sexual health service commissioning within the sexual health strategy will reduce the burden placed on those working in the sector and enable more innovative, patient-centred services to be delivered. This should incorporate a move away from the mandatory tendering of contracts when services are commissioned, alongside the introduction of longer-term contracts for when tendering does occur.