

Written submission

Written evidence from The King's Fund submitted to the Health and Social Care Committee's sexual health inquiry

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Sexual health services are a core part of our health system and are essential to keeping local populations healthy. Not only do they identify and treat individuals with infectious diseases who may experience health complications if left untreated, they also protect the wider population from the risk of transmission and potential epidemics. However, funding cuts to the service are having an impact on provision. Against this background, the Health and Social Care select Committee's inquiry is extremely timely, and we welcome the opportunity to contribute to this.

Spending

1. Unlike the NHS budget, public health, including sexual health, spending has not been protected and has been cut in recent years. It is particularly worrying that funding for this key part of the health system is being reduced at a time when there is growing demand for these services, and diagnosis rates for sexually transmitted infections such as syphilis and gonorrhoea are increasing rapidly (Public Health England 2018). Our research found evidence that cuts are already having an impact in some parts of the country: staffing levels are lower and services are reduced and in some cases closed altogether (Robertson *et al* 2017). Although there is evidence of services innovating to maintain or improve quality, the extent of cuts goes beyond what can be addressed through productivity improvements alone. To avoid further funding restrictions and their impact on service provisions, cuts to the central government public health grant must be reversed.
2. Given the cuts in recent years to central government grants that fund local authority public health budgets, it is unsurprising that spending on local authority funded sexual health services has also been declining. Between 2014/15 and 2018/19 there was an 18 per cent real terms reduction in spending on sexual health services, in line with the 17 per cent real terms reduction in public health

spending per head (after taking into account the effect of new services that have moved into the public health budget) (Finch 2018). Note that Data for 2014/15–2016/17 are outturn; data for 2017/18 and 2018/19 are published allocations. Analysis of budget plans up to 2019/20 shows that cuts are set to continue and deepen to a 25 per cent real terms reduction in sexual health spend between 2014/15 and 2019/20 (Finch 2018).

3. The picture varies across England with some local authorities increasing their spend while others have cut spend by far more than the national trend. This shows that some local authorities are prioritising sexual health spending despite large cuts to their public health grant. Analysis by The King’s Fund of cash terms changes in spending during the period 2013/14–2016/17 found:
 - 40 of 151 (26 per cent) local authorities reduced spend on sexually transmitted infection (STI) testing and treatment services by 20 per cent or more in cash terms; 24 of 151 (16 per cent) increased spend by 20 per cent or more
 - 46 of 151 (30 per cent) local authorities reduced spend on contraceptive services by 20 per cent or more; 47 of 151 (31 per cent) increased spend by 20 per cent or more;
 - 67 of 151 (44 per cent) reduced spend on sexual health advice, prevention and promotion by 20 per cent or more; 45 of 151 (30 per cent) increased spend by 20 per cent or more.

(The King's Fund's Analysis of Department for Communities and Local Government 2015, 2017) *Note: the Scilly Isles did not report data in 2016/17 so have been excluded from the analysis.*

Impact on access and quality

4. Cuts to genitourinary medicine (GUM) budgets are having an impact on access to care in some parts of the country. This includes clinics being closed, moved to less convenient locations or operating with reduced hours. For example, in one instance, a tender that integrated GUM and contraceptive services resulted in a reduction in the number of clinics from 13 to 5 (Robertson *et al* 2017). Reducing the number of clinics is not always a bad thing for patients as it may result in the remaining clinics staying open for longer hours, but through our research we heard of instances where access was made more difficult – for example, towns that no longer had their own GUM clinic. There is also evidence that some patients with symptoms (for whom rapid diagnosis and treatment is particularly important) are finding it harder to get an appointment within 48 hours (Foley *et al* 2017).
5. Financial pressures on services and staffing reductions are forcing some providers to focus on their core diagnosis and treatment function rather than the important broader support that clinics provide to patients, who can have chaotic lives that include drug addiction and sex trafficking issues. Providers and commissioners told us that some services were becoming less holistic (Robertson *et al* 2017). Of

particular concern are cuts to health adviser posts within sexual health clinics. Health advisers are specially trained in partner notification – a key way of halting the spread of STIs among the general population by identifying, testing and treating current and past sexual partners of patients with diagnosed infections. They also provide advice and counselling to newly diagnosed patients and play an important role in prevention.

6. Particularly worrying is the drop in spending on sexual health advice, prevention and promotion services. Our analysis of local authority spending data found spending on these services reduced by 38 per cent in cash terms between 2013/14 and 2016/17 (King's Fund analysis of Department for Communities and Local Government 2015, 2017). These essential upstream services take up a small proportion of the sexual health budget (just 9 per cent in 2016/17 (Department for Communities and Local Government 2017)) but are key in providing targeted sexual health information to at-risk groups. The services are often provided by local voluntary sector organisations who work to shorter-term contracts that are easier to terminate. They are also more susceptible to being decommissioned because they are not mandated services which local authorities are required by law to provide (unlike STI testing and treatment and contraception services). When we interviewed sexual health commissioners and providers about financial pressures they identified these outreach and prevention services as their top priority for additional investment (Robertson *et al* 2017). Our research on HIV services also found that community-based social care support services for people living with HIV were facing similar cuts (Baylis *et al* 2017). The impact of financial pressures on essential sexual health advice, prevention and promotion services and HIV support services is an area that the inquiry should prioritise for attention.

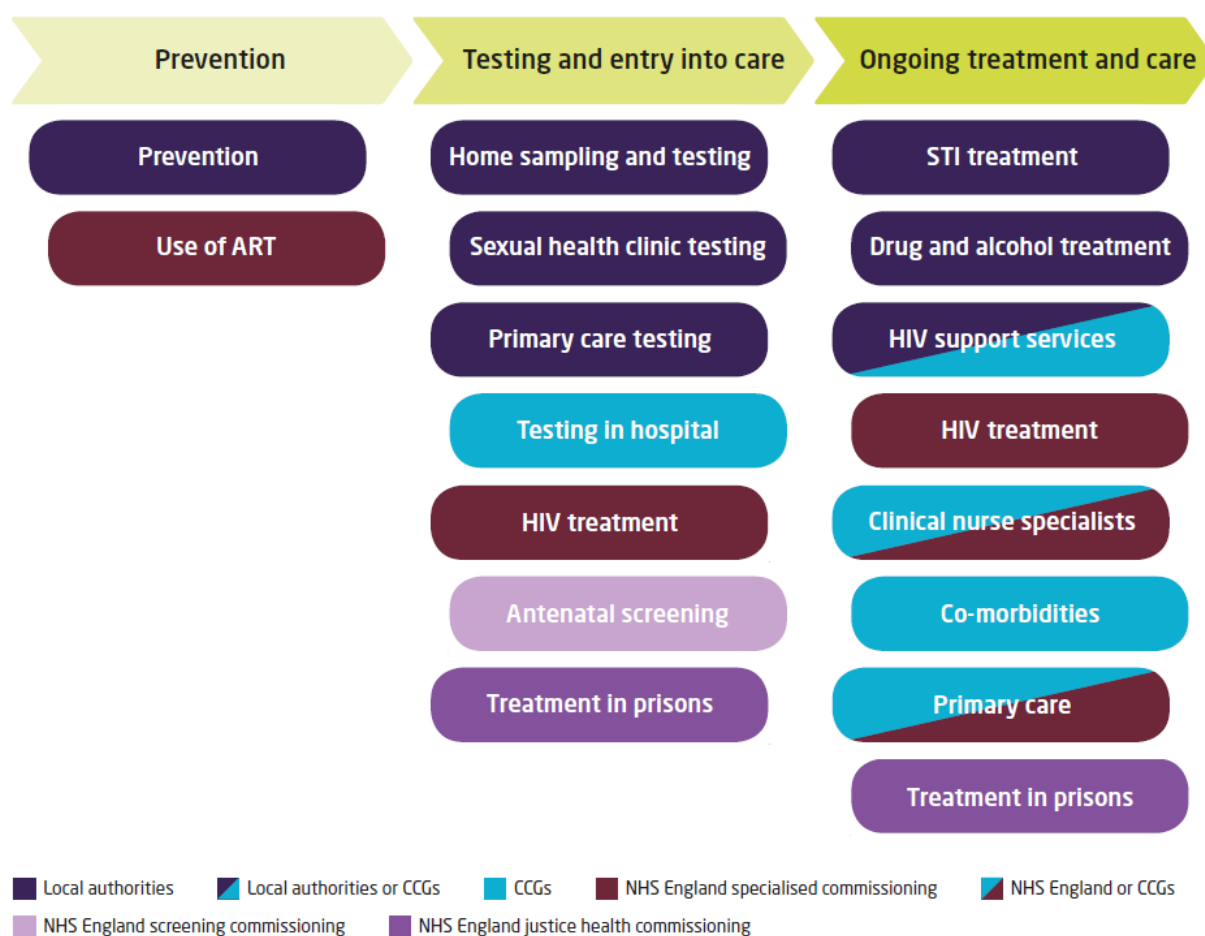
Impact on staff

7. Staff in both provider and commissioner organisations have told us that the uncertainty and changes to services caused by funding cuts, and procurement exercises that put services out for competitive tender put great pressure on staff. This uncertainty is in some cases making it difficult to recruit staff, for example, some services struggled to fill their doctor training places. Some commissioner staff are also struggling to accept the level of budget cuts they were having to implement, with some telling us that because of this they were considering alternative careers (Robertson *et al* 2017).
8. Our research also found that tendering processes were in some cases putting up a barrier between commissioners and providers, meaning that they are sometimes not working together effectively to address the pressures on their budgets and work out the best way to maintain quality and access. The impact of the current pressures on sexual health services on staff morale is another key area for further investigation.

Fragmentation in commissioning responsibilities

9. The changes to commissioning that were introduced in 2013 resulted in three different commissioners of sexual health, reproductive health and HIV services – clinical commissioning groups (CCGs), local authorities and NHS England. Our HIV report highlighted the fragmentation of commissioning across the pathway of care and how many organisations, across local government and the NHS are involved (see Figure 1).

Figure 1 Responsibilities for commissioning HIV care in England



10. In our work on both GUM and HIV services we found examples of this leading to disjointed services and a reduction in their ability to adapt to changing needs (Baylis *et al* 2017; Robertson *et al* 2017). NHS England, local authorities and CCGs each commission different parts of the sexual health and HIV pathway and decisions taken by one commissioner can have a negative impact on the services provided by another. For example, a decision by a local authority commissioner to move a contract for STI testing and treatment services from an NHS provider (who was also providing HIV services) to a non-NHS provider can destabilise the HIV service with many staff being transferred to the new provider. Local commissioners

need to work together to develop a plan for local services across sexual health, reproductive health and HIV. Learning from pilot approaches to joint working must be shared with other local authorities to motivate change.

Accountability

11. There is a lack of clarity about accountability and local and national levels. For HIV services, The King's Fund has called for stronger local system leadership to overcome fragmentation and complexity (Baylis *et al* 2017). This should draw together providers, commissioners and those people most affected by HIV as partners in an overarching plan for each area, with authority to take the plan forward across both NHS and local authority responsibilities. Directors of public health and lead HIV consultants should work together to make sure that the right leadership, structures and governance are in place for each area's needs.
12. Devolution of responsibility for STIs and HIV prevention means that these services should be responsive to local circumstances, but national oversight is essential to provide quality assurance and to prevent and manage the spread of disease in line with existing evidence-based guidance. Data are available for national oversight, for example through local authority returns on use of the public health grant and through the public health outcomes framework, but local services and commissioners are not held to account for these data. The weakness of national accountability is a significant concern.
13. There are examples of good practice where areas have overcome the fragmentation of responsibilities and worked to join up their sexual health and HIV services. It was striking in our HIV work that, while all those we spoke to recognised the issues that fragmentation of commissioning had led to, very few wanted further organisational change and a rewiring of commissioning. Rather, they wanted support to 'get on with it', stronger national leadership to support them to do so and a reversal of funding cuts. This is why our HIV recommendations were based on a local plan with joint local leadership, most likely a clinical leader and a director of public health. In some cases, sustainability and transformation partnerships (STPs) and integrated care systems may provide a home for governance and accountability across the different organisations involved.

HIV services in London

14. In our research we found that London was a striking example of the complex fragmentation of sexual health and HIV responsibilities created by the 2012 Health and Social Care Act, with more than 30 local authorities and a similar number of CCGs and NHS trusts (Baylis *et al* 2017). Given the high rates of incidence of certain STIs in the capital, it is important that STPs and city-wide initiatives are explored. By joining the international Fast-Track Cities initiative for reducing HIV incidence, deaths and stigma, London has shown that it is possible, if complicated, to develop comprehensive city-wide approaches involving local authorities, the NHS, Public Health England and the mayor. Greater Manchester is also

demonstrating this and has recently announced it is joining Fast-Track Cities. With concerted attention and inclusive leadership, comprehensive approaches to prevention and treatment of STIs and HIV are possible across complex cities with multiple organisations.

Innovation

15. There are many examples of innovative working in sexual health and HIV services. In our view, some of these have been the result of changes in commissioning in combination with the need to be more efficient. These include new models of care, new contracting approaches and the introduction of new innovations like home sampling kits that can be ordered online.
16. One example is London's successful 'Do It London' Campaign, which aims to increase the frequency of HIV testing and promote the adoption of safer sexual behaviours. The London HIV Prevention Programme, first established in 2014, is an example of cross-borough collaboration on public health, with all boroughs participating until 2017 and many continuing it beyond this date. The programme has included face-to-face and online outreach work, free condom distribution, and a series of major multimedia campaigns under the brand 'Do It London'. The programme has already achieved significant progress against its core objectives.
17. However, it has required significant efforts to bring the collaboration together, and the programme was seen as being heavily dependent on a few key individuals being willing and able to play a co-ordinating role outside their core job responsibilities. This illustrates the complexity of London – arguably, it should be standard practice to work together on a city-wide basis on an issue like HIV prevention where there are significant spill-over effects across government boundaries and between local government and the NHS. We hope the Fast-Track Cities initiative will help bring this about.

Conclusion

18. Our research highlights:

- the impact of reductions in spend on service provision and on staff morale
- the particularly deep cuts to sexual health advice and prevention activities
- the fragmentation in commissioning responsibilities following the 2012 Health and Social Care Act, which has caused problems in some areas with disjointed services
- the need for better accountability mechanisms and system leadership at local level to develop HIV services.

It also shows that there is innovation happening across England and variation in spending and service changes. Key to the future development of sexual health and HIV services will be sharing learning about how to maintain services in austere times, and approaches to collaborative commissioning and system-wide planning that overcome the disjointed structures established in 2013. In addition to this,

cuts to public health budgets must be reversed to stem reductions in spending on what is an essential clinical service for local populations.

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