British HIV Association
BHIVA

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Baroness Gould
Chair, All Party Parliamentary Group on Sexual & Reproductive Health in the UK
c/o Harry Walker
Policy and Parliamentary Manager
FPA and Brook

By email: appg@fpa.org.uk

Dear Baroness Gould

Launch of Accountability Inquiry into Standards in Sexual & Reproductive Health

BHIVA welcomes the opportunity to give evidence to this Inquiry. Our response is delivered in 2 parts: in section A, we assess progress in relation to **A Framework for Sexual Health Improvement in England** and in this section we include results survey of BHIVA members completed in October 2014; in section B we respond to the specific questions posed.

Please let me know if you have any queries regarding the BHIVA comments.

With kind regards

Yours sincerely

Dr David Asboe
Chair, British HIV Association (BHIVA)

British HIV Association (BHIVA response to the APPGSRH Launch of Accountability Inquiry into Standards in Sexual & Reproductive Health

SECTION A

Scope and suitability of "A Framework for Sexual Health Improvement in England"

Any inquiry into Sexual and Reproductive care based on this framework must first examine the suitability of this framework and in this respect BHIVA feels the document is inadequate. As an STI, all aspects of HIV prevention, diagnosis, treatment and care must be included. In the DH framework description it states that the document sets out the evidence base for sexual health and HIV improvement. We do not believe this is comprehensive, as the only areas of HIV care covered are:

- Reducing onward HIV transmission
- HIV prevention including treatment as prevention (TasP)
- Primary HIV infection
- HIV testing
- Prompt referral into care
- Early diagnosis and treatment of STIs

We note that framework supersedes: "Better prevention, Better Services, Better sexual health, the National Strategy for Sexual Health and HIV". There is a need for a comprehensive national HIV strategy. This should be integrated into a national sexual and reproductive health strategy.

Effects of changes in sexual health commissioning on provision of HIV services

It was predicted that the Health and Social Care Act could lead to fragmentation of sexual health (SHS) and HIV services (HS) and this has happened, seen most acutely in those services where the sexual health component of integrated services has been tendered out. There are examples where SHS have relocated from an acute trust, fragmenting previously integrated services and, in some instances, resulting in loss of income for HS or even closure. In the BHIVA members' survey several examples of this destabilisation were given.

- "Our GUM, contraception and HIV outpatient services are currently being tendered. In the tender specification there is no clarity of the budget allocation for HIV services and it would appear the HIV budget has been absorbed into an integrated sexual health budget."
- "Our service is currently out to tender with the sexual health service. The County Council has refused to tell us how much money in the total budget is for HIV care and how much is for sexual health / contraception"
- "It is likely that the GU service will go out to tender next year. If this is won by a different provider and the service is split this would have a major impact on the quality of care and would increase the cost of HIV care significantly"

- "The GUM service has been tendered separately and the contract just awarded to a provider with no experience of HIV. The HIV service is now unsustainable and likely to close in an area where patients will find it difficult to travel for care."
- "We have been unable to move forward with the centralisation and improvements in of our HIV service as a result of tendering of the GUM service."

BHIVA Members' survey: results

In October 2014, BHIVA surveyed members about the **impact of commissioning changes** on aspects of HIV care. 104 members responded. 32 respondents reported that their GU service had been tendered out.

- **What impact have the changes to NHS commissioning had on the overall quality of care offered to people living with HIV in your area?** 36% rated that care had deteriorated or deteriorated markedly
- **How do you think treatment and care of people with HIV will be impacted in the future by the NHS commissioning changes?** 72% rated that quality of HIV care would decline
- **What impact have the commissioning changes had on your service participation in research?** 21% reported that research had declined or stopped
- **What impact have the commissioning changes had on your service provision of training for specialty trainees?** 22% reported that training had declined or stopped

The following sections are BHIVA's assessment of progress relating to specific HIV aspects contained within **A Framework for Sexual Health Improvement in England**.

HIV Testing

Sexual health services

HIV testing within SHS particularly of those in higher risk groups continues to be comprehensive with a high proportion of attendees having HIV testing included within sexual health screening. These numbers continue to be routinely collected by PHE within GUMCAD. It is not clear if, when or how figures for individual providers are reviewed as part of commissioning or performance review. Additionally it is critical that non-NHS service providers supply the same data.

However this is not the critical HIV testing metric when examining progress within toward reducing the undiagnosed fraction. We would support monitoring of **frequency of HIV testing** in groups with high on-going incidence.

The other critical factor is monitoring of access to HIV testing (both within and without SHS) for higher risk groups. While some data is presented in PHE's HIV report, this data is limited, is not reported by local authority and, to our knowledge, not included in any monitoring or accountability framework.

HIV testing in non-traditional settings

Guidance relating to expanding HIV testing in health settings outside SHS comes from 3 major documents; BHIVA/BASHH/BIS testing guidelines, and NICE guidelines 34 and 35. In addition, the framework notes the DH pilots of HIV testing which reported success. From these guidelines and pilots there is growing consensus that:

HIV testing should be offered to:

- all individuals with an indicator condition (including PHI as above)
- all individuals from a higher risk group
- all individuals within areas of high prevalence presenting for healthcare irrespective of risk factor status and presenting condition

However, following commission changes in 2013, it remains very unclear who should commission, provide and monitor expanded HIV testing, which may occur in hospital, primary care or other community settings. At present, we consider routine access to HIV testing in non-traditional settings to be extremely uneven. Proportion of individuals with late HIV (CD4 <350 cells/microL) at diagnosis are collected and can be accessed by local authority. BHIVA supports the use of these figures to inform commissioning and the provision of expanded HIV testing.

Home sampling

Several home sampling HIV testing pilots have been run. Home sampling is cost-effective and individuals identified as HIV positive have high rates of transfer to care. There is a clear need to expand delivery of home sampling to a 365 day/year service. However, there is no clarity about who or how this is to be expanded if commissioning remains locally delivered. There is a role for national commissioning of cost-effective services which “cross” LA boundaries.

Prompt referral into care

This is a critical component of good HIV care. The high rate of transfer-to- care seen historically is one of the principal reasons that the UK’s “care cascade” is the best in the world. That most HIV testing occurred in sexual health services co-located with HIV services was likely to be an important determinant of this outcome. Now that testing is diversifying away from HIV services, it is critical that transfer-to-care is comprehensively and effectively monitored. PHE do provide some data in their annual report but this data should comprehensively cover all providers and establish clear accountability, which is not currently the case.

HIV Prevention

Treatment as prevention (TasP)

The most acute problems with commissioning/accountability of HIV prevention post Health and Social Care Act relate to (TasP) (defined as: use of antiretroviral therapy (ART) in an HIV positive individual earlier than clinically indicated to reduce the risk of HIV transmission). Consideration of TasP is recommended by all major national ART guidelines, including BHIVA guidelines. Responsibility for commissioning TasP is now with NHS England, who are yet to make a decision. 18% of respondents in the BHIVA survey said TasP was not funded in their service.

Commissioning of other prevention interventions remains with local authorities, representing a fragmented approach to an important facet of public health.

STI screening, diagnosis and treatment, HIV partner notification (PN) for people living with HIV (PLWH)

These initiatives are critical components in reducing HIV transmission (especially PN which is proven to be one of the most cost-effective interventions). Previously, most HIV care was provided within co-located SHS. With the split in commissioning and tendering of many SHS, this relationship is beginning to fracture. Often SHS are moved off-site into community/ other locations while HIV remains on-site. Responsibility for maintaining these services is unclear. While these components were included in the 2012/13 HIV specification, BHIVA is not aware of any data which shows how extensive monitoring of reliable delivery of these components is.

Several BHIVA survey respondents commented on this concerning development:

- "With rising numbers of new diagnoses, standards likely to go down with reduced access, less STI screening, concern regarding falling adherence due to chemsex BUT no formal data collection."
- "The STI element of the service has just been tendered out and given to another provider. This means we have to leave the Trust where the care was integrated and STI will be totally separate from HIV. As it was the same staff delivering both, this is now an impending service nightmare."
- "Unable to screen serosorters for STI."
- "My responses above are from the GU service. The service for GUM was tendered in 2012 and split from the HIV service with resultant relocation of GU away from the hospital. This has resulted in fewer HIV positive patients attending GU for screening. During the period January to December 2013 only 26 of the 360 HIV positive patients attended for GU screening. Reasons quoted by patients included: not wanting to reveal their HIV diagnosis to a new service provider having been used to integrated GU and HIV in the past, they had concerns about confidentiality being maintained. The GU services are now located in a shopping centre and HIV positive patients felt this was not conducive to maintaining their confidentiality. The GU services are now out for tender again."

Endorsement of Faculty of Public Health comments

In addition, BHIVA is pleased to endorse the consultation submission made by Professor Jackie Cassell on behalf of the Faculty of Public Health.

SECTION B

Question	BHIVA response
1. Under the new structural arrangements, which national organisation/s should be accountable for overseeing improvements in sexual and reproductive health services and that the ambitions in the Sexual Health Improvement Framework are delivered? Why do you think this?	The national organisation that should be finally accountable for overseeing improvements in sexual health is NHS England. While PHE has a critical role in collecting and analysing data and advising on service provision and developments, only NHS England has sufficient levers to intervene effectively when necessary (true test of accountability). The prediction that the Health and Social Care Act would lead to fragmentation of integrated sexual health and HIV services has transpired, seen most acutely services where sexual health services have been tendered out. There are examples where SHS has relocated from the acute trust, fragmenting a previously integrated service and in some instances destabilising the HIVS. The ongoing impact of these changes is not being adequately assessed. We believe it is insufficient to rely on **outcomes'** measures alone as these may be late and insensitive markers. More effective oversight of the **process** [tendering] is essential. BHIVA believes that integrated SHS and HS are one of the principle reasons that there is a HIV high transfer to care (following initial diagnosis) rate in the UK, contributing to world-leading HIV care outcomes in the UK. PHE report transfer to care rates. It is vital that data continues to be provided to allow assessment of this critical metric. Example: "Payment by results has helped turn many poor services into excellent ones. However many services are returning to commissioning by block contract. In one service it is reported that in spite of rising demand the Trust is losing interest as under block contract the costs associated with the staffing to provide open-access and pathology outstrips the income. It is difficult to square open access with block contracts no matter how astute one is financially". BHIVA supports activity-based funding and it is difficult to see how this will resolved locally. We feel there needs to be direction and accountability with clout from the centre.
2. At a local level which organisation/s do you believe should be	The current arrangements are fragmented and there are risks and examples of poor

responsible and accountable for overseeing improvements in sexual and reproductive health services, and why?	accountability as a direct consequence of the changes to commissioning. We believe there should be a requirement that HIV and sexual health services are commissioned jointly. We welcome the document "**Making it work: a guide to whole system commissioning for sexual and reproductive health and HIV"**, which attempts to facilitate a collaborative approach to commissioning. However it is too early to judge whether this has made a material difference to the fragmentation in commissioning that currently exists. Without an accountable organisation sitting above local authorities it is difficult to be confident this "best practice" type approach will be effective.
3. What mechanisms within the NHS and public health architecture should be used to hold commissioners and providers to account for the quality and outcomes of sexual health services? For instance, service specifications, performance data and commissioning plans.	There is an important place for a set of national goals, supplemented by locally determined ones. Performance against goals should be assessed by local commissioners irrespective of which organisation sit in. PHE should have a critical role in setting goals but this should be done in conjunction with NHS England, and other professional organisations. Currently accountability mechanisms between providers and commissioners are in place and adequate. There is insufficient monitoring of service specifications and performance of local services at a regional or national level. NHS England with the assistance of PHE should be responsible for this.
4. To what extent has progress been made against specific ambitions of the Department of Health's Sexual Health Improvement Framework? What steps need to be made for these ambitions to be realised?	See SECTION A.
5. How would you assess the quality and availability of data on sexual health outcomes? How can the use and availability of data on sexual health outcomes support greater accountability of service delivery?	Sexual health and HIV outcomes data has until recent events been excellent however the tendering of sexual health services is a real and present threat to the comprehensivity of this data. Maintaining quality data collection across the range of different providers is essential bearing in mind the significant changes to provision which are currently taking place. In a previous question we give the example of transfer to care rates of newly diagnosed HIV positive people as one area of concern.
6. How would you assess the current accountability arrangements for	BHIVA is not aware of any systematic way this is being evaluated. However there are reports from

	ensuring there are sufficient numbers of trained healthcare professionals working in sexual health services? If appropriate, what improvements do you believe could be made to strengthen these arrangements?	a small number of providers that specialist training has not been able to be continued and remedial arrangements for training introduced as a direct result of service reconfiguration and loss of senior supervision. See SECTION A for reports of reduced training opportunities.
7.	What function should the public health system play in ensuring that education plays a role in promoting good sexual and reproductive health?	
8.	To what extent do women and men have choice and access to the full range of sexual and reproductive health services? How can choice in access to sexual and reproductive health services be improved?	