

BASHH and RCP paper on key threats from tendering of sexual health services, November 2013

Introduction

Sexually transmitted infections (STIs) cause clinical diseases but they are also communicable diseases. They therefore require effective clinical services and public health interventions to control their spread.

Sexual health services, also known as Genitourinary Medicine (GUM), provide consultant led expertise in the diagnosis and management of sexually transmitted infections (STIs), including HIV, as well as in primary and secondary prevention. Increasingly they offer contraceptive care in fully integrated services. These services are open access (i.e. patients can self refer and attend any clinic regardless of where they live) in order to ensure rapid access for the diagnosis and treatment of STIs thereby preventing development of complications and reducing onward transmission.

There needs to be close liaison with other associated specialties (e.g. microbiology, virology, dermatology, urology, and obstetrics & gynaecology) to provide safe care pathways, as well as access to the full range of medical specialties and diagnostics for HIV care. Sexual health services also act as a resource for primary health prevention within the community with outreach education to schools, colleges, high-risk groups etc.

From April 2013, the responsibility of commissioning of the majority of sexual health services has been moved from the NHS to Local Authorities who are mandated, through secondary legislation, to provide appropriate access to sexual health services. There are regulations at European, national and local levels which Local Authorities have to follow regarding procuring goods and services. Hence it is their normal practice to tender for all of these. Although health services commissioned by Local Authorities do not require any form of competitive tendering they are still bound by the general obligations of transparency, equal treatment and value for money. Consequently, since taking over the commissioning some Local Authorities have already put services out to tender and others have indicated that they plan to do so. It is expected that most will decide to competitively tender within the next two or three years.

This paper has been produced by the British Association of Sexual Health and the Royal College of Physicians to outline some of the main problems that have occurred with tendering of sexual health services, and with outsourcing of services from the NHS to private and third sector providers.

Six major areas of healthcare at threat from the current process of tendering are identified in this paper:

- 1) **Patient care**
- 2) **Education and training**
- 3) **Research**
- 4) **Health service infrastructure**
- 5) **Public health**
- 6) **Lack of patient and public involvement and lack of accountability**

Key threats from tendering

1) Threats to patient care

Whilst it is important to offer patients' choice and also look for value for money, it is essential that the quality of patient care is maintained. The BASHH/MEDFASH Standards for the Management of STIs (published 2010 and updated for January 2014) were developed for both commissioners and service providers to ensure the delivery of safe, high quality, services.

Emphasised within these is the importance of the provision of the full range of care, from uncomplicated to specialist services, in each health locality, and that clinical management, including treatment options and partner notification, should comply with national guidelines. Appropriate clinical leadership by a Consultant in GUM is essential to safeguard the quality of the service and oversee clinical governance, which must include participation in regional and national audits.

Services put out to tender have reported:

- The process of putting a clinical service out to tender is expensive, requiring input from commissioners, lawyers, accountants, and external clinicians for the procurement and clinicians, managers, accountants, and external consultants for the provider bids. The cost of the procurement, and the cost of the bid from the current provider, comes from the budget for sexual health services thus reducing what is actually spent on clinical care.
- The lead up to the tender process is disruptive for the service (and consequently for patient care) as it causes anxiety amongst staff about the future of their jobs, resulting in staff leaving. Services have been reluctant to fill vacancies due to insecurity of their future income, putting increasing pressure on remaining staff, thus leading to a downward spiral of morale. Even when the service has been awarded back to the original NHS provider a negative effect has remained for several months as highly specialist staff had left and were replaced by less qualified people who required further training.
- When a procurement process has resulted in a different provider being awarded the service, the new provider has not always been able to find suitable premises in the locality. On one occasion this resulted in the service eventually being returned to the original provider meaning the whole procurement process had been a waste of time and money. In another it resulted in a significant reduction of sexual health services for several months until portacabins could be erected to house the new service, meaning the service fell well below that which is mandated.
- A non-NHS provider that was awarded several tenders for high volume, low cost, work was unable to adequately deliver the service as it could not retain staff due to lack of appropriate clinical supervision, leadership and governance.
- In a non-NHS provided service, consultants have been excluded from involvement in service planning and development as well as meetings with commissioners and other key decision makers. Managers have made decisions after consulting with nurses who feel they do not have the expertise or experience to give appropriate advice.
- Non-NHS providers have suggested reducing consultant numbers such that one consultant would be expected to cover clinical services being delivered in several different health localities.
- The term "STIs" is used to cover all the conditions diagnosed and managed in GUM clinics. This is a very simplified but easier term to use in contracts and service specifications. We have heard of instances where non-NHS providers are interpreting this quite literally and are restricting the diagnosis and treatment of other conditions that are not STIs but which should be routine work of all GUM clinics.
- There have been problems with medical records management after transfer of contracts to another NHS organisation or non-NHS providers in that the clinical information from the previous provider is not available



to clinicians within the new service. Many of the conditions diagnosed and managed in sexual health rely on results of previous investigations, and knowledge of previous treatment, for effective care (e.g. recurrent genital herpes, syphilis, hepatitis B and C). Lack of this can adversely affect care and pose a clinical risk. For example, as part of a Health Protection Agency enhanced surveillance and audit in the North East to investigate syphilis in pregnancy following the first cases of congenital syphilis in many years, a non-NHS service could not include all the information requested on its patients as it did not have the clinical details and results from when the service was provided by an acute NHS Trust.

2) Threats to education and training

Sexual health services provide the training for Specialist Trainees working towards a CCT in GUM and Sexual & Reproductive Health, but also provide education and training to doctors working in:

- Obstetrics & gynaecology
- Infectious diseases
- Dermatology
- Contraceptive care
- Microbiology/virology
- General practice, and
- Nurses in Sexual Health and the other specialties listed above as well as Midwives

Moving sexual health services to another NHS provider or to a non-NHS provider fragments and disrupts training in the full range of STI, HIV and contraceptive care, and therefore threatens the specialty and care of people with STIs. It could also impair the maintenance of competence of current practitioners in the field.

- One of the unintended consequences of the change in commissioning, and the current uncertainty for providers around future work and income, is the failure of services to attempt to fill vacant consultant posts. This has a detrimental effect on all training, but especially of Specialty Trainees, as well as service provision.
- Services that had previously trained Specialty Trainees that are now non-NHS provided no longer deliver that training.

3) Threats to research and innovation from tendering

The Health and Social Care Act 2012 places a statutory duty on NHS England, CCGs and Monitor to promote research but only gives powers to Local Authorities to support research with no statutory duties.

Many national research grant giving bodies specify that Principle Investigators (PIs) must be NHS employees and the sponsor must be an NHS body. Local Authority commissioned services, provided by a non-NHS provider, are not NHS services so any existing PIs transferred to such services will be unable to continue their research role and will be ineligible to apply for future research funding (even if supported by the LA). This will reduce departments' abilities to undertake sexual health research in England and will create inequalities for patients' access into research studies.

Short-term service contracts, of two or three years, do not offer any long-term income security for providers. There is therefore no incentive for service providers to invest in future developments, improvements or innovations, when the cost of the investment may not be recoverable.

- Some Local Authorities have not included research as part of their service specification when putting their sexual health services out to tender. This has led to large geographical areas being disengaged from research after being taken over by non-NHS providers who have declined to recruit patients into national portfolio studies or provide research support.

4) Threats to the health service infrastructure due to fragmentation from tendering

Commissioners need to consider the close inter-relationships between clinical services. For instance, most sexual health and HIV treatment and care services are delivered from within the same premises by the same staff. This integration makes clinical sense because HIV is sexually transmitted and both the transmission and acquisition of HIV are increased by the presence of other STIs. The Local Authority's ethos of tendering means there is a risk of these services becoming geographically separated with reduction in quality of service.

Each reorganisation of sexual health has some inevitable disruption to clinical care. Repeated tendering of services every few years, with the possibility of different providers each time, destabilises services and increases the likelihood of clinical risks.

- In the majority of locations, sexual health and HIV treatment services are delivered from within the same premises by the same staff. In many areas HIV treatment and care is dependent on the wider infrastructure provided by the sexual health service. When sexual health service tenders have been won by other NHS providers or non-NHS providers, the NHS Trusts running joint sexual health and HIV treatment services have no longer found it viable to continue to provide HIV treatment services independently. This has left HIV patients at risk until their care is transferred to a new provider and it reduces the quality of the services since comprehensive sexual health care is no longer provided on site.
- In one area, the high volume, low cost, work was put out to tender (the acute Trust provider was told it would not be considered as the commissioners wanted a community based provider). This work was then awarded to a different provider with the expectation that the acute Trust would continue to provide the complex specialist care. The income versus the cost of the complex specialist care using the flat rate GUM PbR tariff meant that this was not financially viable so the Trust had to withdraw its provision of complex specialist STI care leaving patients without this service.

5) Threats to public health from tendering

The current focus on integration of GUM and contraception will clearly improve services for women but this may make services less attractive to men, particularly men who have sex with men (MSM). Yet MSM are considered a 'hard to reach' group with high rates of STIs, the highest levels of antibiotic resistant gonorrhoea, the highest ever number of new HIV diagnoses in 2012 and high rates of on-going HIV transmission. The 'one-stop-shop' principle of sexual health service delivery for women will be at the expense of the 'one-stop-shop' care that MSM living with HIV have had with GUM and HIV treatment delivered together.

This division of GUM and HIV services through tendering is likely to have a negative public health impact. HIV is sexually transmitted and both the transmission and acquisition of HIV are increased by the presence of other STIs. Hence many people living with HIV are at risk of STIs and people with STIs are at higher risk of acquiring HIV. Indeed we are seeing rising STI rates being reported in people living with HIV. Fragmenting the services will make these more difficult to diagnose meaning people will be infected for longer which will result in increased complications and increased onward transmission.

Reducing the late diagnosis of HIV is one of the public health outcomes. A recent national audit of partner notification of sexual contacts of people diagnosed with HIV in 2011 showed that of the partners notified, 21% were newly diagnosed as HIV positive. Thus, HIV partner notification is the most effective way of identifying undiagnosed HIV but it may take weeks or months to perform effectively. The process can be continued by the sexual health advisors where GUM and HIV treatment and care services are delivered together but if they are fragmented it needs to be handed over to the HIV service. The results of the national audit indicated that the number of contacts tested per HIV index case by HIV services not linked to GUM was well below the UK national average. Further fragmentation of GUM and HIV services will therefore reduce the effectiveness of HIV partner notification.

Appropriate use and understanding of different microbiological tests is essential for the safe provision of sexual health services and to optimise patient care. This requires close liaison with microbiology/virology laboratory staff. Rapid communication from the laboratory to the clinical service is also essential for serious or unexpected results, so they can be acted upon urgently. This is becoming increasingly important with rising gonorrhoea resistance to antibiotics.



Such links have often been in place for years in NHS settings where the clinical service is located near to the laboratory.

If services are fragmented there is the risk of failing to identify sexually transmitted infection outbreaks due to the lack of knowledge of expected numbers and patterns of infections. For example, a gonorrhoea outbreak in young heterosexuals was recognised in the North East on the basis of the number of cases of gonorrhoea that historically would be expected in one year being seen within a few months. If those cases had been spread amongst a few providers, especially ones who had no prior knowledge of the expected prevalence, timely diagnosis of, and response to, the outbreak may not have happened.

- Some non-NHS providers of GUM services do not provide partner notification for newly diagnosed HIV infection; instead they pass this onto the HIV service. This will result in fewer sexual contacts being tested and fewer new HIV diagnoses being made.
- Non-NHS providers use centralised private laboratories for microbiology/virology tests. This disrupts the close working relationship between the local laboratory and sexual health services with loss of clinical collaboration.

6) Lack of patient and public voice and lack of accountability

Disruptive changes for patients in health service delivery, or provision of poor quality care, are usually met with outcry and complaints from the patients and the public, e.g. children's cardiac surgery reconfiguration and the Mid Staffordshire NHS Foundation Trust. However, because of the stigma, and the negative societal attitudes attached to STIs, service-users and the public have not complained about these examples of reductions in access to care and poorer quality of care.

In the absence of patients and the public raising concerns when services have fallen below those mandated, it is essential that there are lines of accountability beyond Local Authorities. Yet it appears that Public Health England and the Department of Health have no formal powers to address Local Authority commissioning decisions.

Summary

Health services commissioned by Local Authorities do not require any form of competitive tendering but they are bound by the general obligations of transparency, equal treatment and value for money. Commissioners should therefore consider if a competitive procurement process is the most cost-effective, and sustainable, way of improving care rather than a continuous improvement programme which is developed with the provider.

Local Authority commissioners should not make decisions in isolation but should work with those responsible for specialist commissioning of HIV treatment and care. They should consider the adverse effects of destabilising the integration of services, and risks to patient care and public health, by moving to different providers. Joint commissioning would optimise the prevention, treatment and care of STIs and HIV.

If tendering is chosen, the ability to provide suitable premises for delivery of clinical care, and a mechanism for the transfer of electronic patient records or case notes, should be explicit in the tender process. The impact on HIV services should be considered as well as the provision of research, education and training. Good and effective integrated clinical care pathways, and multidisciplinary working arrangements, take years to establish and are easily destroyed.

There needs to be clear lines of accountability between Local Authorities and Public Health England to ensure that problems with commissioning can be resolved quickly to avoid reductions in quality of care and to enable interventions where sexual health services have fallen below that which is mandated.

Dr Janet Wilson
President of BASHH

Dr David Daniels
Chair of the RCP JSC in
Genitourinary Medicine

Sir Richard Thompson
President, Royal College of Physicians
London



For full details on our accreditation visit: www.nice.org.uk/accreditation