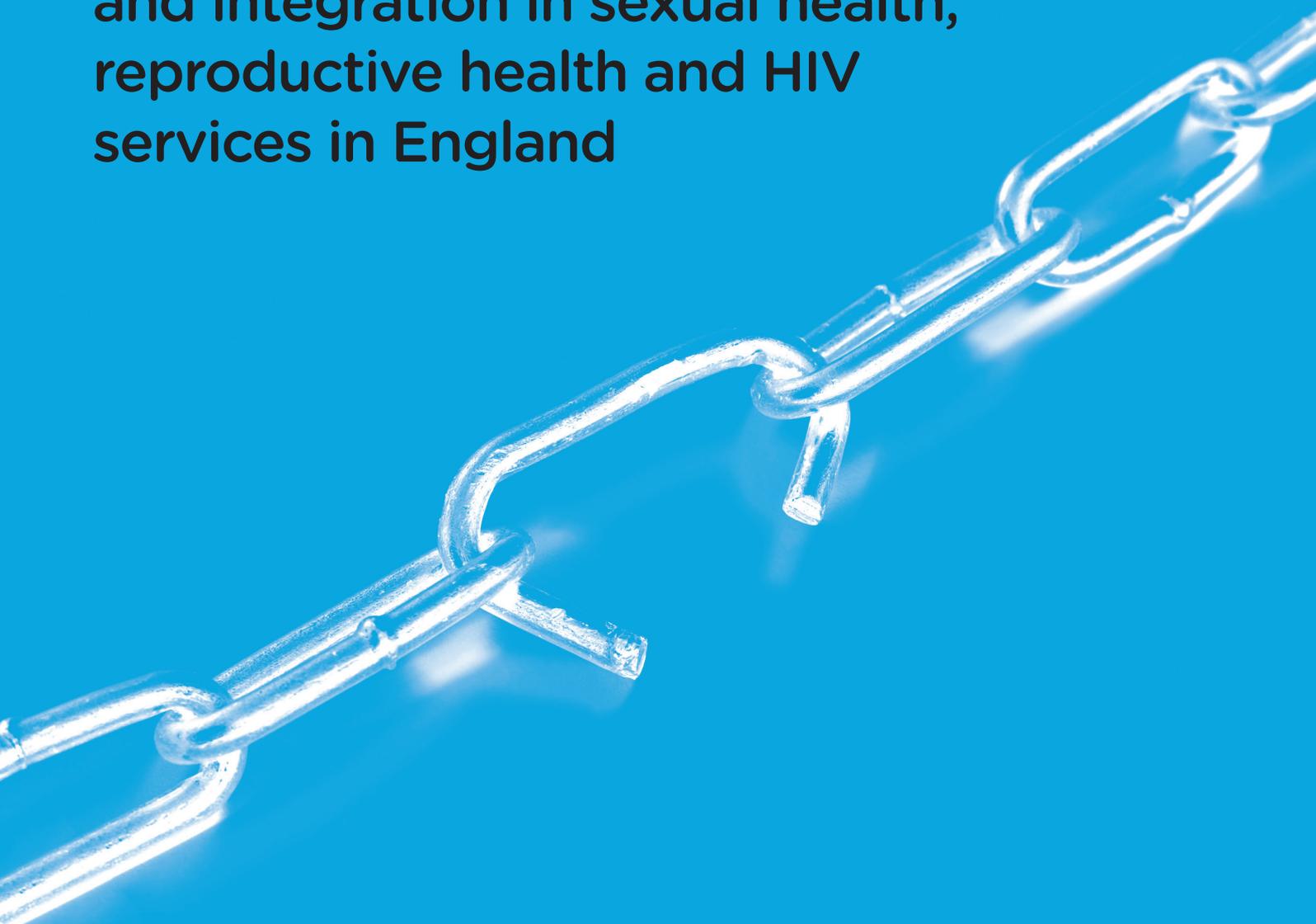


## Breaking down the barriers:

### The need for accountability and integration in sexual health, reproductive health and HIV services in England



---

FPA acts as the secretariat to the APPG on Sexual and Reproductive Health in the UK, with support from FSRH and BASHH. The Advisory Group on Contraception (AGC) provided administrative services only to this inquiry. The secretariat of the AGC at the time of the inquiry was provided by MHP Communications whose services were paid for by Bayer HealthCare. Editorial control rests with the APPG alone.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. The views expressed in this report are those of the group.



# Contents

	Page
1. Foreword .....	2
2. Introduction .....	3
3. Executive summary .....	4
4. Summary of key recommendations .....	9
5. Background .....	11
6. Accountability .....	13
7. Commissioning responsibilities .....	20
8. Monitoring, evaluation and data .....	27
9. Financial and contracting barriers .....	31
10. Future funding .....	35
11. Workforce education and training .....	37
12. School and population-wide education .....	40
13. Patient and user involvement .....	43
Annex 1 – Individuals providing oral evidence to the inquiry .....	45
Annex 2 – Terms of reference for the All-Party Parliamentary Group on Sexual and Reproductive Health inquiry into accountability and integration in sexual health, reproductive health and HIV services .....	47
Annex 3 – Full list of responsibilities by commissioner .....	50
Annex 4 – References .....	51

# 1. Foreword

Sexual health, reproductive health and HIV services were some of the areas most impacted by the structural changes established in the Health and Social Care Act. As these changes were implemented the All Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) began to hear from stakeholders working in these areas that the changes were leading to fragmentation in commissioning and service provision which was creating silos in previously integrated areas of public health.



The APPGSRH conducted this inquiry in response to the concern that patients and service users were missing out, and that provision was not always being designed around what would best support and suit service users needs. This inquiry set out to understand what impact the new structures have had on sexual health, reproductive health and HIV services - both good and bad - and to identify where things could be done differently to improve patient experience and outcomes.

It has not been possible to cover all issues faced by those who need and use sexual health services, for instance the parity of sexual health rights of people with disabilities and learning difficulties, where clearly far more data is required and information provided. Nor have we dealt with the critical need for the HPV vaccine to be made available to boys as well as girls. These and other allied subjects will be considered by the APPG at its future meetings.

Meanwhile I hope that you find the report of value and I would like to thank all those who submitted written evidence and who provided oral evidence to the panel. I would also like to thank my fellow panel members who gave up their time and who have provided a great amount of expertise to this inquiry which covered a large and complex area which is of vital importance to the whole of society.

**Baroness Gould of Potternewton**  
**Chair, All Party Parliamentary Group on Sexual and Reproductive Health in the UK**

## 2. Introduction

The All Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) is a cross party group of peers and MPs, which was established to facilitate discussions between parliamentarians and stakeholders on sexual and reproductive health issues. The group has a history of supporting and initiating broader parliamentary activity around sexual health, reproductive health and HIV, and facilitating visits for policymakers to see services in action in order to broaden their understanding of best practice in sexual health.

The APPGSRH launched an inquiry in August 2014 to consider what the accountability framework should look like for sexual health, reproductive health and HIV services in England, and to make recommendations about how these structures can be improved in this vital area of public health.

The inquiry was chaired by Baroness Gould of Potternewton, Chair of the APPG on Sexual and Reproductive Health in the UK, and supported by an expert panel consisting of:

- Dr Jan Clarke – President, British Association for Sexual Health and HIV
- Dr Kathy French – Independent Nurse Adviser
- Alison Hadley OBE – Director, Teenage Pregnancy Knowledge Exchange, University of Bedfordshire
- Jane Hatfield – Chief Executive, Faculty of Sexual and Reproductive Healthcare
- Ruth Lowbury – Chief Executive, MEDFASH (Medical Foundation for HIV & Sexual Health)
- Sir Nick Partridge – Vice Chair, Sexual Health Forum
- Lord Rea – Member, APPG on Sexual and Reproductive Health in the UK
- Baroness Tonge – Vice Chair, APPG on Sexual and Reproductive Health in the UK
- Chris Wilkinson – President, Faculty of Sexual and Reproductive Healthcare

The APPG issued a call for written evidence from individuals and organisations involved in sexual health, reproductive health and HIV services. This included policymakers, providers, commissioners and service users. 35 submissions of written evidence were received.

In addition to written evidence, the panel is very grateful to the witnesses who provided oral evidence during the four evidence sessions. A full list of individuals who provided oral evidence can be found in Annex 1.

The full terms of reference for the inquiry can be found in Annex 2.

# 3. Executive summary

## Accountability

- The Health and Social Care Act fundamentally reorganised the NHS, public health and social care. New national bodies were established, including NHS England and Public Health England, but lines of accountability have never been clearly set out. This has led to a lack of proper oversight of the quality and outcomes delivered by commissioners.
- Clarification about national accountability in sexual health, reproductive health and HIV should be a priority action for the Department of Health. Without this, the APPG believes that there is insufficient national coordination to enable local commissioners to work together in an effective way which meets the needs of service users in their area. This has to be addressed as a matter of urgency.
- Clinical commissioning groups (CCGs), local authorities and NHS England clearly need to be accountable for improvements delivered by the service providers they commission for sexual health, reproductive health and HIV. This is important in order to deliver good patient experience and outcomes, and to foster innovation across systems and organisations.
- Directors of public health and health and wellbeing boards (HWBs) need to work together to improve integration between services commissioned by the NHS (including general practice) and those commissioned by public health.
- Directors of public health and HWBs should promote partnership and joint working, and support evaluation and communication strategies between local providers to ensure that services are organised around patients' needs.

## Commissioning responsibilities

- Changes in the commissioning landscape led to structural divisions in commissioning between the NHS, public health and social care. This reorganisation had a significant impact in the division of commissioning responsibilities for sexual health, reproductive health and HIV.
- Local government is well positioned to think broadly and work with partners, such as housing, criminal justice, adult services, leisure, education, social care, and children and young people, and to help drive integration across the wider health economy.
- There are multiple interdependencies between different services and the division of commissioning responsibilities is leading to services being commissioned in new silos built around the commissioning structures and not service users.
- Sexual health, reproductive health and HIV are at the cutting edge in responding to the new commissioning arrangements put in place by the Health and Social Care Act. As such, their progress should be closely followed and used as an exemplar to share learning about how to avoid fragmentation in the services that people receive and to highlight how the different parts of the system should work effectively to deliver joined-up services and deliver good outcomes and experiences for patients and the general public.

- Local authorities are mandated to commission confidential, open access services for STIs and contraception. Many areas are providing a good range of open access services, however, there is evidence of restrictions in access to contraception and STI testing based on age and place of residency. It is therefore clear that the mandate needs to be clarified in order to give local authorities a more prescriptive list of services which must be included and on what terms.
- To date, some local commissioners may not have necessarily had the time or been equipped with the knowledge and skills to commission in collaboration with local partners to take a whole system approach. One example where local authorities need more support is in medicines management and the use of patient group directions (PGDs). Local authorities are now allowed to authorise PGDs but there is no specific guidance for them on the “how to”.
- To minimise wasted resources and ensure an offer of comprehensive services (including prevention) to those at greatest risk, it is important that epidemiologically informed advice is obtained by commissioners who may have limited knowledge of sexual health outcomes and their determinants. Good quality, regular needs assessments are essential in providing the information needed to make local commissioning decisions based on the local population and their specific needs.
- This fragmentation in service provision has had a profound effect on patients and those who need to access services. Commissioning open access services could deliver a significant cost saving to the public purse and commissioners of sexual health, maternity and social care services, as well as having a positive impact on patients and service users.

## Monitoring, evaluation and data

- Data has an important role to play in informing and stimulating best practice commissioning and in making sure that if areas are underperforming, this is identified early and tackled.
- At present there is no national monitoring of progress against the ambitions set out in the Department of Health’s *Framework for Sexual Health Improvement in England (The Framework)*. The Department of Health should establish an indicator set to monitor and measure progress against the ambitions of *The Framework* and require commissioners and providers to report progress against these indicators. In addition, the Department of Health should publish an annual report setting out progress towards the delivery of the ambitions in *The Framework*.
- Currently, the way that datasets are collected means that there is no one place which can provide a full picture of the data for sexual health, reproductive health and HIV. The development of sexual health profiles by PHE is a welcome step forward, but these are not comprehensive and do not bring together all of the information needed about sexual health, reproductive health and HIV. Particularly important is the need to link GP data with other data in sexual health, reproductive health and HIV.
- In order to supplement the information collected by providers and commissioners, it would be useful to collect information directly from the public to understand their views and knowledge about sexual health, reproductive health and HIV services. Data collection should always include elements of public and patient opinion and feedback. Community level public involvement exercises to collect public opinion and assess awareness of local sexual health, reproductive health and HIV services are useful additions to service user consultations.

## Payment, tendering and contracting barriers

- Services are currently funded using tariff and block contracts. Often these different funding mechanisms are within the same integrated service and can distort service provision and access in a way unrelated to need. Commissioners should use a single funding mechanism, either the tariff or a block contract, across all services to avoid distortions in provision that can arise when there are income-driven incentives to prioritise one service over another, regardless of patient need.
- Concerns were expressed to the inquiry about the reality of putting services out to tender and the unintended consequences this has produced. In some cases tendering can cause a breakdown of collaboration between providers and where procurement is short-term, services find it difficult to plan improvements as they may not retain contracts over the longer term. This reduces the incentive to provide continuing education and training and development for staff and encourages providers to only deliver services to the letter of the contract.
- Service specifications should follow a common national quality and standards framework to ensure a consistent basic standard of care.
- A comprehensive sexual health needs assessment should be undertaken before services are put out to tender and at re-tendering to ensure that they are going to provide the right services for the locality.

## Future funding

- Services commissioned by local authorities are funded from the public health budget which is currently ring-fenced. Sexual health accounts for about one quarter of local councils' public health grant spend but this in itself is not protected.
- In June 2015, the Department of Health announced that it will consult on cutting £200 million from the public health budget in 2015/16. This equates to over 7% of the overall public health budget. It is undoubted that budget cuts in local authorities for activity labelled as public health will not only result in reductions in the service they commission but will create knock-on costs for the NHS.
- Compounding the impact of these potential cuts, evidence was presented to the inquiry stating that this budget is not always being spent by local authorities directly on public health services. Public Health England should have a clear role in overseeing how money from the public health ring-fence is being spent and to feed back to, and where necessary, challenge local authorities on how the monies are being used.
- We would urge the Department of Health to extend the period of the ring-fence for public health when this is considered as part of the Spending Review in the autumn.

## Workforce education and training

- Education and training of the workforce must be viewed as a fundamental aspect of effective and sustainable health service planning and delivery, ensuring that patients continue to receive the highest standards of care. Ongoing education and training should therefore be a mandatory inclusion in provider contracts.
- Without an appropriately skilled workforce and enough capacity generated by having the healthcare professionals with the right skills, access and choice in provision will become limited.
- There is little national direction on the development of the sexual health, reproductive health and HIV workforce. Local education and training boards (LETBs) should undertake a local needs assessment. In addition, Health Education England (HEE), should have a stronger role to play nationally in ensuring that the shape and skills of the future sexual health, reproductive health and HIV workforce is able to evolve to sustain high quality outcomes for patients.
- Locally commissioned providers are responsible for ensuring that there are sufficient staff to deliver the service and outcomes that have been commissioned. This should be detailed in service contracts and specifications. Contracts also need to build in time for innovation, by having the ability to release staff to do research to promote medical and service improvements.

## School and population wide education

- Changing attitudes and improving awareness and education about sexual health, reproductive health and HIV are key ways of improving outcomes.
- Sex and relationships education (SRE) lays the foundation of knowledge and skills to equip young people to understand consent, and make positive and well informed choices about their sexual and reproductive health. Good SRE is associated with later sexual debut, condom and contraceptive use, and a reduced risk of pregnancy before 18 and non-volitional sex. Increasing awareness about sexual health, reproductive health and HIV has a significant impact on personal wellbeing and financial savings in service provision. Retaining a focus on public awareness and education is important.
- Despite the efforts of individual schools and local authorities, the quantity and quality of SRE remains seriously inadequate, with Ofsted verifying this to be the case in a third of all schools. Children and young people themselves repeatedly describe the SRE they receive as “*too little, too late*”. In a recent survey 27% of respondents described SRE as bad or very bad and 25% reported that they had learned nothing about HIV and AIDS.
- Sex and relationships education should be made a statutory subject for all schools including academies and free schools. The inquiry recommends that the Government implements the February 2015 recommendation of the Education Select Committee that sex and relationships education and PSHE should be statutory subjects in all primary and secondary schools.
- Promoting sexual health needs to take a life-course perspective. Therefore, different approaches need to be taken for different populations, with tailored messages delivered through channels which will be most engaging to the specific group.

## Patient and user involvement

- Patient and user involvement is an important part of accessing sexual health, reproductive health and HIV service design and delivery. Consumers should have an official route to help commissioners and service providers to build local services which draw on the practical considerations of service users.
- In some local areas and provider settings there are clear and established routes for engagement with patients and service users, but in other areas there is a lack of established voice which makes the need for effective and meaningful user involvement even more imperative.

## 4. Summary of key recommendations

---

**Recommendation 1** – As a result of the Health and Social Care Act, commissioning arrangements for sexual health, reproductive health and HIV have become complex and fragmented. The Secretary of State for Health has overall accountability for the delivery of sexual health, reproductive health and HIV services, and therefore must clarify and publish a clear accountability structure in which the responsibilities for each government department and arm's length body are set out. The Department of Health, as steward of the system, must monitor and challenge the contribution of each of these national bodies.

---

**Recommendation 2** – The Department of Health should require that Directors of Public Health, working with health and wellbeing boards, scrutinise local commissioning decisions and local service provision. As a core part of helping to manage the health and wellbeing of the population, Directors of Public Health and health and wellbeing boards should be supported to review data on sexual health, reproductive health and HIV and develop plans to act on the findings of this data review. As part of this, the Department of Health should establish an indicator set to monitor and measure progress against the ambitions set out in the Department's own *Framework for Sexual Health Improvement in England* and require commissioners and providers to report progress against these indicators.

---

**Recommendation 3** – Sexual health, reproductive health and HIV are at the forefront of the new commissioning arrangements put in place by the Health and Social Care Act. As a 'vanguard' of a new approach to commissioning, including integration of clinical services within local authority commissioning, these arrangements deserve to be well supported and evaluated with lessons learned that can be applied elsewhere. This area of healthcare could be used as an 'exemplar' of how to achieve effective commissioning across the NHS and local authorities if it is given sufficient resources and evaluation for learning to be achieved and shared.

---

**Recommendation 4** – Public Health England has some excellent datasets for STIs and HIV, however it doesn't collect data for reproductive health. Additionally, there are gaps where good quality data are not collected, especially from general practice. This makes it difficult to get a view of sexual health, reproductive health and HIV as a whole. Public Health England should be tasked to collect all the relevant data sets in order that they can be used together to measure progress and monitor the impact of innovations in sexual health, reproductive health and HIV services. Public Health England should also be required to act on the findings from these data, by supporting and challenging local authority and NHS commissioners, health and wellbeing boards, and Directors of Public Health.

---

**Recommendation 5** – A new national standard contract should be put in place which sets out minimum standards for providers. Before services are put out to tender, as part of the commissioning cycle, a thorough needs assessment should be undertaken to determine the requirements of the local population, taking account of demand, service capacity, and the needs of specific groups as well as the general population. Commissioners should be required to act on the findings of the needs assessment and be scrutinised by the health and wellbeing board in relation to progress against the needs assessment. Contracts should ensure that the same funding mechanisms are used across services (in particular in integrated services) as the use of different funding mechanisms is currently leading to severe distortions in service delivery.

---

---

**Recommendation 6** – The public health ring-fence should be retained beyond 2016, and the Secretary of State should commit to protect the public health budget to ensure all aspects are funded, including prevention and clinical services.

---

**Recommendation 7** – Local authorities are mandated to commission confidential, open access services for STIs and contraception, but there is a need for clear guidance about what this means to ensure local authorities understand what they must commission. Based on the detailed explanation of mandated services, local authorities must be held to account over their spending of the public health budget. The Secretary of State should clarify which national body will hold local authorities to account for their spending.

---

**Recommendation 8** – Health Education England should conduct a review and publish a report about future workforce needs in sexual health, reproductive health and HIV, setting out required service capacity, skill mix, under-graduate and post-graduate education and ongoing training needs. HEE should require that local education and training boards (LETBs) work with local authority and NHS commissioners and providers to ensure that a training and education needs assessment is conducted at the local level. Based on the needs assessment, training should be built into the service specification of contracts in order to protect time and funding for training and education.

---

**Recommendation 9** – The Department for Education should implement the recommendation of the Education Select Committee that sex and relationships education and PHSE should be made statutory subjects in all primary and secondary schools.

---

**Recommendation 10** - Patient and user involvement is key to ensuring that services are designed to be accessible to all those who require them, where and when they need to use them. Commissioners and providers need to involve the whole range of people accessing sexual health, reproductive health and HIV services, including those working and in good health, in the design and review of services.

# 5. Background

Good sexual health, reproductive health and HIV services are fundamental to protecting and improving the health and wellbeing of the nation. This can be through reducing health inequalities, improving the health of children and young people, and supporting prevention and early intervention initiatives, while also addressing the wider determinants of health and wellbeing. It should therefore be a priority for any Government to ensure that sexual health, reproductive health and HIV services are high quality, open access and deliver good outcomes.

The Health and Social Care Act 2012 (the Act) led to wide ranging changes in the way that the health service is organised, particularly in relation to the commissioning of services. The consequences of the Act were wide ranging for sexual health, reproductive health and HIV services and caused significant concern among stakeholders. The changes in the Act were intended to bring commissioning closer to patients and communities and allow provision to be based around people’s needs in sexual health, reproductive health and HIV. These responsibilities are set out in Figure 1 below:

**Figure 1: Summary of commissioning responsibilities<sup>1</sup>**

Clinical commissioning groups	NHS England	Local authorities
<ul style="list-style-type: none"> <li>Termination of pregnancy services</li> <li>Contraception for gynaecological purposes</li> <li>Non-sexual health elements of psychosexual health services</li> <li>Sterilisation</li> <li>HIV testing when required in other CCG commissioned services</li> </ul>	<ul style="list-style-type: none"> <li>Contraceptive services provided under the GP contract</li> <li>HIV treatment and care</li> <li>HIV testing when required in other NHS England commissioned services</li> <li>STI testing and treatment provided under the GP contract</li> <li>Cervical screening</li> <li>HPV immunisation programme</li> </ul>	<ul style="list-style-type: none"> <li>Contraception primarily delivered in community clinics</li> <li>STI testing and treatment</li> <li>Chlamydia screening</li> <li>HIV testing, prevention, sexual health promotion and social care</li> <li>Young people’s sexual health services</li> <li>Services in schools</li> <li>Sexual health aspects of psychosexual counselling</li> </ul>

In advance of the commissioning arrangements taking effect in April 2013, the Department of Health published *A Framework for Sexual Health Improvement in England<sup>2</sup> (The Framework)* in March 2013. *The Framework* explained the need for joined-up working, coordination and innovation from commissioners and providers in order to ensure new arrangements deliver for patients and the public. It also set out a number of ambitions for the future of sexual health, reproductive health and HIV services in England. The APPG agreed with these ambitions and received representations from a number of organisations about the positive work being carried out to deliver against the aims of *The Framework*.

The APPG became aware of persistent challenges, particularly regarding the leadership, expertise and accountability needed to ensure the delivery of a consistent and effective service.

Even more worryingly, it was reported to the APPG that changes in commissioning were leading to:

- Restrictions in access for patients.
- Fragmentation between providers which in the past delivered integrated care, making it more difficult and time consuming for service users to get all of the support they needed.
- Patients having a poorer experience of their care as a result.

Since the inquiry commenced, Public Health England has published *Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV<sup>3</sup> (Making it work)*. This document was produced by MEDFASH (the Medical Foundation for HIV & Sexual Health) for Public Health England, with support from the Department of Health, the Local Government Association, Association of Directors of Public Health and NHS England.

*Making it work* provides the information, evidence base and support tools to enable those involved in sexual health, reproductive health and HIV commissioning to work together effectively. It is very helpful in clarifying a number of areas of commissioning responsibility which were unclear in *The Framework*. This report is not intended to replace this practical guide, but rather to identify where things are working well and also to provide a critical appraisal of where challenges have been identified. The new Government has made clear that there will be no further national reorganisations of the NHS, public health and social care systems. The APPG is therefore making recommendations about how, working within the current system, more accountability could be brought into the structures, supporting innovation in delivery, in a way which meets people's needs and enhances people's experiences of care.

## 6. Accountability

---

**Recommendation 1** – As a result of the Health and Social Care Act, commissioning arrangements for sexual health, reproductive health and HIV have become complex and fragmented. The Secretary of State for Health has overall accountability for the delivery of sexual health, reproductive health and HIV services, and therefore must clarify and publish a clear accountability structure in which the responsibilities for each government department and arm's length body are set out. The Department of Health, as steward of the system, must monitor and challenge the contribution of each of these national bodies.

---

**Recommendation 2** – The Department of Health should require that Directors of Public Health, working with health and wellbeing boards, scrutinise local commissioning decisions and local service provision. As a core part of helping to manage the health and wellbeing of the population, Directors of Public Health and health and wellbeing boards should be supported to review data on sexual health, reproductive health and HIV and develop plans to act on the findings of this data review. As part of this, the Department of Health should establish an indicator set to monitor and measure progress against the ambitions of *The Framework* and require commissioners and providers to report progress against these indicators.

Accountability is important to service users and patients, as it helps them understand and influence who is responsible for maintaining and improving the care they receive. Clear lines of accountability also enable the wider health system to monitor and evaluate what is being delivered in sexual health, reproductive health and HIV services. This requires service standards, outcomes and quality to be monitored.

### The role of national bodies

As previously stated, the Health and Social Care Act fundamentally reorganised the NHS, public health and social care. As a result of this reorganisation a number of new national bodies were established, including NHS England and Public Health England, which took on a number of the former responsibilities of the Department of Health and the Secretary of State for Health.

A common theme identified in the evidence submitted to the inquiry was concern about the lack of clarity identifying who is ultimately responsible at a national level for sexual health, reproductive health and HIV services, and what powers they have to drive up standards and outcomes across the country.

*“It is difficult to identify clear lines of national responsibility within the new sexual health commissioning structure. There seem to be no requirements on any organisation at national level to drive improvement and there are concerns that there are insufficient protocols in place for intervention to occur where problems arise.”*

**British Association for Sexual Health and HIV (BASHH)<sup>4</sup>**

In her oral evidence, Parliamentary Under Secretary of State for Public Health, Jane Ellison MP, was asked to explain which body or bodies have national accountability for sexual health, reproductive health and HIV services. She stated:

*“The overall responsibility to Parliament in the end falls to the Secretary of State, and the stewardship of the system is something the Department of Health takes forward.”*

**Jane Ellison MP, Parliamentary Under Secretary of State for Public Health<sup>5</sup>**

Despite this clarification from the Minister, there appear to be limited mechanisms for the Secretary of State and the Department of Health to drive improvement, and no clear way or obligation for national bodies to intervene over poor performance in local commissioning and provision and the effect on patients.

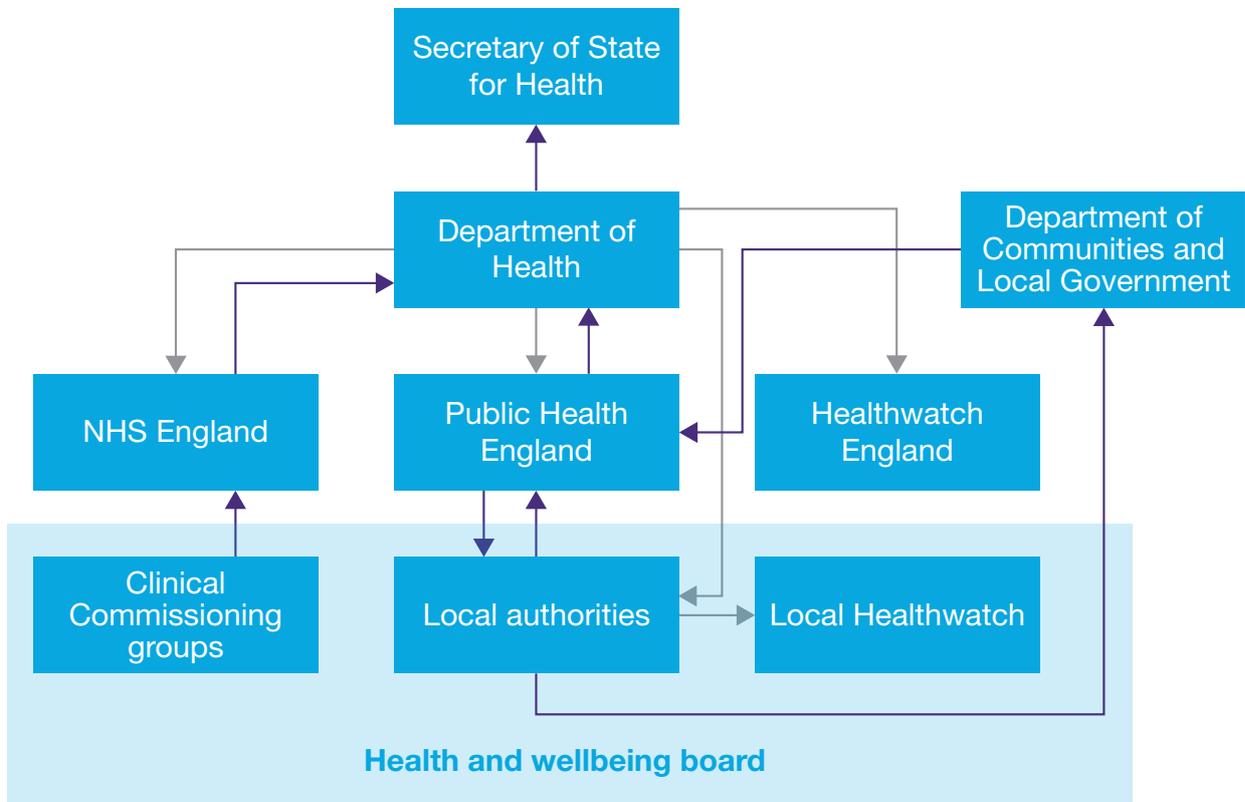
In advance of commissioning responsibilities being reallocated, the Department of Health published *The Framework* in March 2013. It was disappointing that this document did not set out where accountability lies. In order to address these gaps, additional information about national accountability was provided in *Making it work*. Despite this clarification, it remains difficult to identify clear lines of national accountability for sexual health, reproductive health and HIV.

*“As *The Framework* does not include a definition of success, for example a target to reduce HIV transmission by, it is difficult to measure progress against this ambition. This also means that it is difficult to use *The Framework* to hold the Government to account on the HIV related aims.”*

**National AIDS Trust (NAT)<sup>6</sup>**

Figure 2, below, sets out how the funding flows and data returns are currently built into the system architecture for sexual health, reproductive health and HIV services. While these do not in themselves represent a fully functioning accountability structure, these are the elements where there is the clearest information about how the system is expected to link together.

**Figure 2: Funding flows and data returns for sexual health, reproductive health and HIV<sup>7</sup>**



**Key:** Funding flow —> Data Reporting —>

The role of each of the relevant national bodies should be clarified in relation to sexual health, reproductive health and HIV. Based on evidence presented to the inquiry, in addition to the existing responsibilities identified, the following roles should be formally established:

### Department of Health (DH)

- Should have overall accountability for the delivery of sexual health, reproductive health and HIV services and national outcomes.
- Should establish an indicator set to monitor and measure progress against the ambitions of *The Framework* and require commissioners and providers to report progress against these indicators.
- Should have a clear line of oversight of NHS England in its role as a commissioner of services in this area. The DH should have the power to intervene if NHS England is not delivering its commissioning responsibilities effectively.
- Should establish a ministerial committee bringing together stakeholders, patients and government.

---

### NHS England

- Should report to the DH on its local and national commissioning responsibilities.
- Should be required to respond to concerns identified by Healthwatch England.

---

### Public Health England (PHE)

- Should make recommendations to the DH about what data needs to be collected about sexual health, reproductive health and HIV services.
- Should be given formal powers and responsibility to act on the findings of the data it collects and analyses, including the ability to challenge commissioners on their performance.
- Should be required to respond to concerns identified by Healthwatch England.

---

### Health Education England

- Should conduct a review and publish a report about future workforce needs in relation to both capacity and skills.
- Should work with local education and training boards (LETBs) to conduct a local workforce education and training needs assessments.

Public Health England has stated that it will consult on a strategic plan on health promotion which will include sexual health, reproductive health and HIV. This will set out commitments and priorities for the next three years. Depending on the outcomes of the consultation, this may provide some helpful clarity around PHE's role in health promotion.

## Regulation

There is an important role for regulators to play in holding providers to account for the quality of the services they deliver. The Care Quality Commission (CQC) is a key regulator of provider activity and behaviour, above and beyond simply delivering their contractual obligations. In evidence provided by the CQC, it has clarified the extent to which its inspection regime includes sexual health and reproductive health services.

General sexual and reproductive health services are identified in community health care services. The CQC uses *"a sampling based approach to assess which service lines within the core service to inspect ... Given the sampling approach, sexual and reproductive health services are therefore not a service that will be included in every inspection – they may be included if particularly large or if information suggests they should be looked at."*<sup>8</sup> Having a clearer understanding about the regulatory role that the CQC is playing in holding providers to account is very helpful.

The findings of two recent CQC inspections, which included sexual health, reproductive health and HIV services, were shared with the APPG. A summary of these is outlined in the box below.

**Solent NHS Trust** – “This NHS trust provides community health and mental health services. The inspection took place in March 2014 and was part of the initial pilot of our new inspection approach. It therefore did not result in a rating being given. As the sexual health services were very large, it was considered appropriate to inspect sexual health services as a specific core service ... The inspection found particular concerns with the time that people had to wait to access sexual health services.”

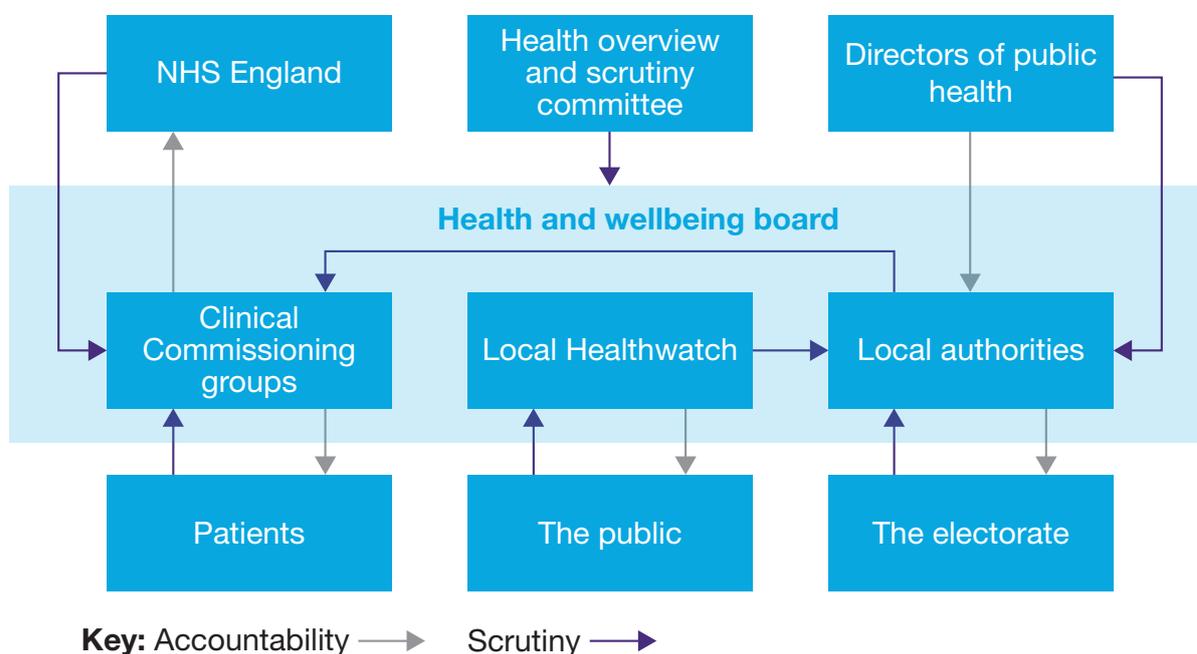
**Chelsea and Westminster NHS Foundation Trust** – “This acute NHS foundation trust was inspected in July 2014. It provides the most extensive HIV and sexual health service in Europe. Therefore it was agreed that it was appropriate to consider and rate these as a separate core service. We found a number of areas of innovation and overall the service was rated as outstanding.”

**Care Quality Commission<sup>9</sup>**

## Local accountability

Alongside national accountability, ensuring that commissioners and providers are accountable locally is critically important in order to support the delivery of improvements in the health and wellbeing of local populations. Figure 3, below, sets out the bodies at the local level who are charged with designing and overseeing local commissioning and outcomes.

**Figure 3: Local accountability and scrutiny<sup>10</sup>**



Given the powers that local bodies have in designing services, it is important that there is stronger oversight of local commissioners in order to ensure that services are available and are delivering good outcomes for patients and service users.

CCGs, local authorities and NHS England clearly need to be accountable for improvements delivered by the service providers they commission for sexual health, reproductive health and HIV. To make the system work and deliver holistic service provision for the local population, commissioners must be held to account over how they demonstrate joint, collaborative approaches to commissioning across pathways. This is important to deliver good patient experience and outcomes, and to foster innovation across systems and organisations.

*“Whilst local authorities’ responsibility for sexual health makes them accountable to the local electorate, there is a danger that sexual health may not be viewed as a vote-winning issue, particularly given low voter turnout among young people, who are most affected by sexual ill health.”*

**Terrence Higgins Trust (THT)<sup>11</sup>**

## The role of health and wellbeing boards and directors of public health

To deliver a whole system approach in sexual health, reproductive health and HIV services, directors of public health and health and wellbeing boards (HWBs) need to work together to improve integration between services commissioned by the NHS (including general practice) and those commissioned by public health. Directors of public health and HWBs should promote partnership and joint working between local providers to guarantee that services are organised around patients’ needs.

HWBs were identified in a significant amount of the evidence presented to the inquiry as important bodies in driving integrated working locally between different commissioners. However, according to Local Government Association data, only 13 HWBs have specifically prioritised sexual health in their work programme<sup>12</sup>. This may be appropriate based on local needs, but HWBs should be required to explain why they prioritise different areas, and the director of public health should have a key role in determining what these priorities should be.

*“It is important that local areas be given autonomy to allocate their resources according to local priorities. We recognise the thin line between the localism agenda and the need for national priorities to be resourced and addressed. However, allowing local health and wellbeing boards to select the prioritised indicators for investment would help to steer finite investment and resources to address inequalities and deliver better outcomes nationally.”*

**The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)<sup>13</sup>**

In order to develop a standard local framework of accountability across all commissioners of sexual health, reproductive health and HIV services, directors of public health and HWBs should have formal powers to scrutinise and act on commissioning decisions. This can identify ways in which different commissioners can work together and spread innovation. Additionally, directors of public health and HWBs should be supported by Public Health England to review information and data about local performance and act on these findings.

## Conclusion

Clarification about national accountability in sexual health, reproductive health and HIV should be a priority action for the Department of Health. Without this, the APPG believes that there is insufficient national coordination to enable local commissioners to work together in an effective way, which meets the needs of service users in their locality. This has to be addressed as a matter of urgency.

## 7. Commissioning responsibilities

---

**Recommendation 3** – Sexual health, reproductive health and HIV are at the forefront of the new commissioning arrangements put in place by the Health and Social Care Act. As a ‘vanguard’ of a new approach to commissioning, including integration of clinical services within local authority commissioning, these arrangements deserve to be well supported and evaluated and lessons learned that can be applied elsewhere. This area of healthcare could be used as an ‘exemplar’ of how to achieve effective commissioning across the NHS and local authorities if it is given sufficient resources and evaluation for learning to be achieved and shared.

The changes in the commissioning landscape are set out in Figure 1. It was anticipated that local commissioners and provider organisations could overcome these ‘back office’ divisions and for joint working and integration to flourish around the specific needs of the local community. In some areas these aspirations are being realised, and innovation and tailored approaches are being implemented which have a very positive effect for local patients and communities, but, as reported, in many areas these structural changes have created a complex and fragmented system in sexual health, reproductive health and HIV services.

This approach to commissioning should be welcomed, particularly as local government is well positioned to think broadly and work with partners such as housing, criminal justice, adult services, leisure, education, social care, children and young people, and to help drive integration across the wider health economy.

*“Placing the commissioning of sexual health services with local authorities has not been without its challenges - but it has also opened many doors, from a public health perspective, for example the links with education, children and young people services, safeguarding and CSE agendas, youth and community services, Families First, school nursing – all sitting under the LA umbrella (with health visiting and Family Nurse Partnership to follow), the local authority links with further education colleges, school governors with a responsibility for sexual health policy and the links with social care for those working in the HIV field.”*

**The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)<sup>14</sup>**

Examples of joint working are beginning to emerge, and we welcomed the evidence provided to the inquiry by a number of areas which have developed plans to support a joined-up approach in commissioning local services. We also welcomed a recent publication by LGA and MEDFASH that set out case studies for how this is working in practice<sup>15</sup>.

It is clear that, despite the examples of good practice, silos have emerged, leading to system-wide fragmentation. The Government has made clear that there will be no further national reorganisations of the health service. Therefore it is imperative that we are able to learn from the areas of challenge and fragmentation, and innovation and success, and create a system which is sustainable for the future, building on the great steps forward which have been taken in sexual health, reproductive health and HIV over the last decade.

## Fragmentation in commissioning across specific condition areas

*Making it work* sets out a vision for joined-up, whole system commissioning and provides practical information to commissioners about how to take this approach in their locality. In principle the models set out in *Making it work* are a practical response to show how the different parts of the system can work together to ensure that the structural challenges in sexual health, reproductive health and HIV commissioning can be overcome and minimise the impact these have on service users. We would urge all commissioners to use *Making it work* to help deliver a whole system approach to commissioning.

*“The past year has been a transformative time. The commissioning arrangements have undergone radical changes, with the aim of creating locally relevant responses to improve the sexual and reproductive health of people and populations, while seeking to increase equity for high-cost prescribed HIV services nationally. Much has been achieved, but further work is needed to ensure a seamless linkage between national and local commissioning.”*

**The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)<sup>16</sup>**

There are a number of examples of areas which have taken a joined-up approach to commissioning with promising outcomes for service users, however, the impact and outcomes of these examples are not yet evaluated. There are a number of examples where commissioning divisions are creating challenges and unintended consequences for commissioners, providers and service users, including:

- **Money not following the patient** – Women can experience restrictions in access to the full range of contraceptive methods, despite the clear evidence that it is cost effective to prevent unwanted pregnancies with contraception. One explanation for this is reported to be because contraception is commissioned by local authorities and NHS England (through the GP Contract), while abortion services are commissioned by CCGs. Therefore the investment local authorities make in contraception reduces unintended pregnancies, which prevents abortions and reduces demand on maternity and abortion services which are paid for by the CCG. Finances are clearly not the only motivating factor in commissioning decisions, but without the money following the service user there is no financial incentive to pay for preventative activity which will create savings elsewhere in the system. Restrictions in access to contraception are being reported as a result of this.
- **Duplicate commissioning pathways limiting access** – Contraception for gynaecological (non-contraceptive) and contraceptive purposes is commissioned by two different bodies. Therefore in some areas where a woman is seeking contraception for gynaecological purposes this is now only available in hospital, but the same method is available in a community clinic for contraceptive purposes. Services should be built around women’s needs rather than commissioning silos.
- **Disruption of a patient pathway** – STI testing and contraception is not always available to women in the same service where they have an abortion. This creates a barrier in access for women who are often vulnerable and who may not seek testing or contraception elsewhere.

- **Physical separation of previously integrated care** – Previously the provision of STI and HIV services were often integrated and delivered in one location. These services are now commissioned by different bodies and in some cases STI services have been relocated away from the acute trust where HIV treatment is delivered without the involvement of NHS England HIV commissioners. These integrated services were a key point of contact in the lives of people living with HIV and relocating STI testing, potentially reducing the quality of care they receive. Splitting services in this way may also render the HIV service unviable if there is not a large patient caseload.

In written evidence provided by the LGA and the ADPH, it was noted that “Public health teams in local government have tried to ensure that HIV commissioning is linked effectively with local sexual health service commissioning but this has proved challenging with a complex commissioning system.” It has been reported to the inquiry that there is ongoing work considering whether co-commissioning should be implemented in HIV. There are still questions about whether this approach will help address fragmentation and also questions about whether NHS England will co-commission with local authorities, CCGs or both. The clinical reference group (CRG) on HIV is currently considering the impact and processes for co-commissioning. We urge the CRG to make rapid recommendations about co-commissioning and would support the piloting of a range of different models to ensure commissioning is joined-up and responsive to local needs. It is important for HIV commissioners to recognise the co-dependency of HIV and GUM services.

*“Recent changes in the commissioning and delivery of services do however have the potential to disrupt team working. The separate commissioning of sexual health and HIV services impacts significantly on genito-urinary medicine clinics that provide HIV care. Where tenders have led to the delivery of services by alternative providers, which may be geographically separate, this will impact on staffing, experience levels and joined up care.”*

**MSD<sup>17</sup>**

It is imperative to create a long term solution for sexual health, reproductive health and HIV. Bringing together the NHS, public health and social care budgets at a supra-local level in Greater Manchester is the first example where structural barriers are being broken down to challenge complexity, while also breaking down silos to achieve the overall outcomes that patients and the local communities desire.

Further evidence showed that investment in preventing teenage pregnancy can have a much wider positive impact beyond sexual health, reproductive health and HIV:

- Children born to women under 20 were at a 63% higher risk of living in poverty.
- Babies born to women under 20 were at a 41% higher risk of infant mortality.
- Mothers under 20 were twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout pregnancy.
- Mothers under 20 were one third less likely to initiate breastfeeding and half as likely to be breastfeeding at 6-8 weeks.<sup>18</sup>

The field of sexual health, reproductive health and HIV is on a journey to adapt successfully to the new commissioning arrangements. Progress should be closely followed and used as an exemplar to share learning about how to avoid fragmentation in the services that people receive and to highlight how to deliver integrated, joined-up working between local authorities and NHS commissioners. Ultimately this will spread learnings more widely about how to deliver joined-up services that demonstrate good outcomes and experiences for patients and the general public.

## Open access and choice

Local authorities are mandated to commission confidential, open access services for STIs and contraception. As set out in *The Framework*, a key principle of sexual health services since their inception is that they are confidential and open access, and that a referral from a GP or other health professional is not required, and services are not restricted by place of residency or age. There are strong public health reasons why the open access nature of these services should continue.

Many areas are providing a good range of open access services, however there is evidence of restrictions in access to contraception in some settings based on the age of the woman and their place of residence. Restrictions have also been reported in STI testing based on age.

*“The AGC’s first audit of commissioners in England, Sex, lives and commissioning, found that over 3.2 million women of reproductive age (15-44) were living in areas where fully comprehensive contraceptive services, through community and/or primary care services, were not provided – representing almost one third of women in England of reproductive age. Restrictions included limits on access to both services and contraceptive methods. The follow up audit, Sex, lives and commissioning II, also uncovered evidence of restrictions that appeared to contradict national guidance and policy. Many of the restrictions reported were based on a woman’s age, which in some areas affected whether they were able to access free emergency hormonal contraception from pharmacies through enhanced service arrangements.”*

**Advisory Group on Contraception (AGC)<sup>19</sup>**

These restrictions, based on age, place of residence, or type of contraceptive, are clearly not in line with the spirit of open access provision. This evidence underpins the need for a clearer mandate to be given to local authorities about a more prescriptive list of services which must be included, and on what terms.

The inquiry also heard examples where choice was being restricted. The Women of Walthamstow, a group of women who have been campaigning for the last three years to improve the provision of sexual health services in the Walthamstow area, told us that their group was established when they were unable to access contraception from their local GP practice. This meant that they did not have a choice, but had to attend a community sexual health clinic for their contraception.

*“Previously women registered at the Addison Road practice, where GPs did not provide contraception, faced a difficult bus journey to Oliver Road clinic in Leyton, often with children in tow, and with no fixed appointments. Others were accessing contraception advice from central London provisions, such as Camden’s Margaret Pyke Centre.”*

**Women of Walthamstow<sup>20</sup>**

## Supporting commissioners to fulfil their role

Some local commissioners may not necessarily have had the time or been equipped with the knowledge and skills to commission in collaboration with local partners to take a whole system approach. *Making it work* goes some way to help fill the knowledge gap and upskill commissioners, but more needs to be done to enable commissioners to break down the artificial barriers which have been created by the new structures.

*“The artificial distinctions between HIV and STI treatment and split of HIV prevention responsibilities between LAs, CCGs and NHS England has made it important that sexual health commissioners work the ‘whole system’.”*

**The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)<sup>21</sup>**

Local authorities are still adjusting to the new areas of responsibility they have taken on, especially where they are commissioning clinical services such as contraception and STI treatment. The LGA has taken a leading role in supporting this transition, but all local commissioners need more support to be able to work together and deliver coordinated service provision.

*“Members of the contraceptive community have expressed concern about fragmentation of services and ‘the capacity of local authorities to commission complex clinical sexual health services’.”*

**Bayer HealthCare<sup>22</sup>**

One example where local authorities need more support is in medicines management and the use of patient group directions (PGDs). PGDs are operational documents with a strict legal and governance framework which, in specified circumstances, allow supply and administration of medicines to patients by named, registered healthcare professionals who are not prescribers. Many sexual health and reproductive health services use PGDs because the services are predominantly nurse delivered or provided in community pharmacy, with no immediate access to a prescriber. In 2013, legislation changed to allow local authorities to authorise PGDs but there is no specific guidance for them on

the “how to”. Whilst pharmacists are working with local authorities to help them understand how medicines management, including the use of PGDs should be built into commissioning frameworks, local authorities need more support and clarification about how to commission clinical services, including those which require PGDs.

*“I have come across a number of instances where commissioners have not understood or have not read PGD guidance or related information with resulting consequences. For example: community pharmacy EHC service provision delayed or suspended because of failure to identify pharmaceutical support for the development and/or authorisation of Patient Group Directions (PGDs); and use of expired PGDs for supply of EHC for several months in a service due to a failure in handover in transition from PCT to LA followed by lack of clinical governance. The commissioner was struggling to understand PGDs and had no knowledge of clinical governance mechanisms for review/update and authorisation of PGDs.”*

**Angela Bussey, Royal Pharmaceutical Society representative (sexual health) and National PGD Website Specialist Pharmacist<sup>23</sup>**

## Needs assessment

To minimise wasted resources, and ensure an offer of comprehensive services (including prevention) to those at greatest risk it is important that epidemiologically informed advice is obtained by commissioners who may have limited knowledge of sexual health outcomes and their determinants. The need for commissioners to have access to this type of data is set out in more detail in Chapter 8. This is an important resource used in local needs assessments to enable better planning of services which are specific to the needs of the local population.

Good quality, regular needs assessments are essential in making good commissioning decisions based on the local population and their specific needs. Compared with other health outcomes, sexual health outcomes vary between different population groups to an extreme degree. For example, the risk of HIV acquisition varies more than five-fold by sexual orientation, gonorrhoea 14-fold by ethnicity, while both pregnancy and abortion rates in under 18s are strongly related to socio-economic status. It is only by understanding these factors and how they apply to a local health economy that a proper commissioning plan can be put together.

Research conducted by the Advisory Group on Contraception found that 31% of LAs had never carried out a needs assessment of their contraceptive services and did not have one planned.<sup>24</sup> Without collecting this data, it is not possible for local authorities to understand the contraceptive needs that exist across their local area, or to assess how the model of service provision is impacting outcomes.

## Conclusion

Commissioning silos have had profound effects on patients and those who need to access services. Commissioning open access services could deliver a significant cost saving to the public purse and commissioners of sexual health, maternity and social care services, as well as having a positive impact for patients and service users.

The reallocation of commissioning responsibilities across multiple commissioners nationally, and indeed within a locality, has led to clear challenges in the design and delivery of sexual health, reproductive health and HIV services. Services are now becoming increasingly fragmented, with patients often having to access multiple services from different providers, impacting on the quality and experience of care that they receive. To increase the opportunities for collaboration and ensure that truly open access services are offered to people at sites convenient to them, commissioners must be supported in this role. This will help them work together to design joined-up services that not only present opportunities for delivering cost efficiencies, but ultimately better meet the needs of all local residents.

## 8. Monitoring, evaluation and data

---

**Recommendation 4** – Public Health England has some excellent datasets for STIs and HIV, however it doesn't collect data for reproductive health. Additionally, there are gaps where good quality data are not collected, especially from general practice. This makes it difficult to get a view of sexual health, reproductive health and HIV as a whole. Public Health England should be tasked to collect all the relevant data sets in order that they can be used together to measure progress and monitor the impact of innovations in sexual health, reproductive health and HIV services. Public Health England should also be required to act on the findings from these data, by supporting and challenging local authority and NHS commissioners, health and wellbeing boards, and Directors of Public Health.

Using data to measure and monitor progress against outcomes can be one of the most effective ways to identify good practice. It can also identify areas which are struggling, and, by sharing the experience and learnings from sites of good practice, support them to make changes so that they are able to improve.

### Measuring progress against the ambitions in *The Framework*

As previously highlighted, at present there is no national monitoring of progress against the ambitions set out in *The Framework*. This means there is no clear agreed set of data measures and there is no central way of tracking progress.

If *The Framework* is to be meaningful, then progress against its ambitions must be collected and analysed in order to chart improvements and to identify areas which are failing. These data must be presented to local commissioners and the Department of Health to enable the setting of a clear action plan to make sure that the ambitions can be achieved.

There are some measurable ambitions in *The Framework* which could be mapped on to data which are already collected and reported by PHE through its Sexual and Reproductive Health Profiles. Examples of datasets which would help to monitor progress include:

- Chlamydia Testing Activity Dataset (CTAD).
- Genitourinary Medicine Clinic Activity Dataset (GUMCAD).
- Sexual and Reproductive Health Activity Dataset (SRHAD).

Public Health England should map out how to use these existing datasets to measure progress against the ambitions, and identify where there are gaps. The Department of Health should publish an annual report setting out progress towards the delivery of the ambitions in *The Framework*. Within these reports the Department of Health should invite NHS England and Public Health England to report back on their own work to deliver these ambitions.

## Supporting local oversight of progress

Currently, the way that datasets are collected means that there is no one place which can provide a full picture of the data for sexual health, reproductive health and HIV. The development of sexual and reproductive health profiles by PHE is a welcome step forward, but these are not comprehensive and do not bring together all of the information needed about sexual health, reproductive health and HIV. Particularly important is the need to collect more data from general practice and link it with other data in sexual health, reproductive health and HIV.

*“Effective use of available data is hampered by the use of different data collection mechanisms and information being managed separately and often there is a lack of compatibility which makes building a complete and useful picture, nationally and locally more difficult. However, there still exists a paucity of data to measure sexual and reproductive health service performance and cost of services – particularly in general practice. There is an absence of key indicators, such as prevention of pregnancy and pregnancy outcomes across different population groups, ease of access and evidence of being offered an effective choice of contraceptive methods.”*

**Faculty of Sexual and Reproductive Healthcare<sup>25</sup>**

In order to improve the information reported and to generate insight for commissioners and providers from these data about how their local area is performing, PHE should review the existing range of datasets across the system, with identification of gaps, duplication and redundancies in current datasets.

One area where data are currently being collected is in relation to the Public Health Outcomes Framework<sup>26</sup>, which has a number of indicators relevant to sexual health, reproductive health and HIV including:

- Chlamydia detection rate
- Population vaccination coverage – HPV
- Under 18 conceptions
- People presenting with HIV at late stage of infection

PHE currently monitors progress against these and provides quarterly updates but there is no formal way of enforcing these as standards. For instance, there appear to be no national sanctions if services such as chlamydia screening are no longer offered within a local area<sup>27</sup>. While these indicators are very limited in terms of mapping outcomes in relation to sexual health, reproductive health and HIV, if there is an ongoing commitment to monitor these areas nationally, then there must be a route to hold local commissioners to account over their performance on these indicators.

*“Whilst it is useful to use outcomes data [from the Public Health Outcomes Framework] to hold providers accountable for outcomes as opposed to outputs, we need to be aware that sexual health outcomes are affected by a wide range of determinants not all of which are under the control of sexual health service providers.”*

**Brook<sup>28</sup>**

Data collection can be onerous on providers. Contract managers have reported that they have to feed data into so many different organisations, including commissioning bodies, all wanting different things at different times which is adding to cost and the necessary workforce to deliver this. The key metrics which should be monitored are those which confirm that patient outcomes are improving and support the building of a system focussed around service user needs.

It is also important that the data being collected is compatible and can be used to build a more sophisticated analysis of what is happening in sexual health, reproductive health and HIV services. It was noted in some evidence presented to the inquiry that data collection systems can be a barrier. The inquiry heard that the majority of sexual health services have IT systems and software in place. These help to collect and analyse outcome and activity data both locally and nationally, however these systems are less well developed in contraception, and clinics should be supported to develop them<sup>29</sup>.

Once agreement has been reached about which data need to be collected, PHE is best placed to monitor service improvements. It is essential that PHE makes a commitment to developing and optimising methods for monitoring the extent to which vulnerable groups are identified and engaged in appropriate care. Additionally, it will be essential that in analysis of sexual health, reproductive health and HIV, the data are interpreted pragmatically, understanding that many of the determinants of sexual health, reproductive health and HIV outcomes are outside the control of the NHS and public health services.

PHE local teams should work with commissioners and providers to analyse these data to inform and stimulate the spread of best practice. PHE should be given formal power and responsibility to act on the findings from these data, by supporting and challenging local authority and NHS commissioners, health and wellbeing boards, and Directors of Public Health.

*“PHE have the data and national overview. This can provide expertise to support delivery and drive up quality through working with local areas where there appears to be variation in sexual health outcomes. They have the workforce to deliver with scientists, researchers and public health professionals. Are they accountable...why not!”*

**Leeds City Council<sup>30</sup>**

Outcomes of service change on aspects such as patient experience, pregnancy rates and disease incidence are especially important to measure in a rapidly developing area such as sexual health, reproductive health and HIV. Evaluating novel interventions such as self-testing and self-sampling for HIV needs constant review of the relevance of data collection, and to have a baseline of evidence so that the impact of these new approaches can be monitored.

## Understanding the consumer view of sexual health, reproductive health and HIV

In order to supplement the information collected by providers and commissioners, it would be useful to collect information directly from the public to understand their views and knowledge about sexual health, reproductive health and HIV services. Conducting a consumer survey would help to establish a baseline, which could then be monitored annually. This could include questions about choice, access, knowledge and culture in these areas.

## Conclusion

Given the wide range of commissioners and providers working in sexual health, reproductive health and HIV, a more complete dataset should be developed that can monitor improvements and ensure that the progress which has been achieved over the last decade in outcomes is not reversed. This will mean that patients can continue to benefit from the advances in care standards seen in recent years.

## 9. Financial and contracting barriers

---

**Recommendation 5** – A new national standard contract should be put in place which sets out minimum standards for providers. Before services are put out to tender, as part of the commissioning cycle, a thorough needs assessment should be undertaken to determine the requirements of the local population, taking account of demand, service capacity, and the needs of specific groups as well as the general population. Commissioners should be required to act on the findings of the needs assessment and be scrutinised by the health and wellbeing board in relation to progress against the needs assessment. Contracts should ensure that the same funding mechanisms are used across services (in particular in integrated services) as the use of different funding mechanisms is currently leading to severe distortions in service delivery.

Effective commissioning involves funding services in a way which stimulates collaboration, innovation and high quality. Thorough understanding about the contracting process and development of service specifications is also essential to reflect local needs, and drive improved outcomes and experiences for patients using these services. Evidence received by the inquiry suggests that opportunities are being missed on both these fronts due to changes in commissioning responsibilities, with unintended consequences on the quality of services that people receive.

### Payment mechanisms

Before the changes introduced by the Health and Social Care Act, most sexual and reproductive health services were funded by block contracts, while GUM services were paid for through the national GUM Payment by Results tariff. Following the establishment of the new commissioning structures, commissioners are able to decide which type of funding mechanism they would prefer to use when they commission services. The main features of each of these funding mechanisms are:

- **Block contracts** – These are contracts which pay a fixed sum of money to provide a service set out in a specification. These are often seen as good for commissioners because they enable them to predict and control the level of expenditure even in open access services, regardless of the amount of activity services undertake. These contracts do not stimulate service innovation that aims to improve the reach or quality of services. When these types of contracts are awarded, the local authority is paid based on where the service is located and not where the service user lives.
- **Tariff** – A tariff allows service providers to be paid for the activity delivered. This can be better for providers because they are paid for their actual activity by the local authority in which the patient resides – and it may stimulate service innovation – but it means that local authorities don't have the same level of financial certainty that a block contract provides.

Many local authorities have now moved to commissioning GUM services via block contracts rather than through the tariff. From a service user perspective it should not make a difference whether a service is funded by a block contract or through payment by results if good back-office management structures are in place.

There are areas where GUM is on tariff and sexual and reproductive health services are funded by block contracts. Often these different funding mechanisms are within the same integrated service. This can distort service provision and access in a way unrelated to need. In order to stop this happening commissioners should use a single funding mechanism, either the tariff or a block contract, across all services to avoid distortions in provision that are built around potential to drive income rather than patient need.

Also raised in evidence submitted to the inquiry were challenges about out of area commissioning and ensuring that cross-charging for activity which takes place out of area is effective. A specific example was provided by the City Health Care Partnership based in Hull. They expressed concern about their difficulty in reclaiming money where they had provided care for residents from other areas<sup>31</sup> and the resultant impact this has on their budget and ability to plan services for the local population.

*“Cross charging for sexual health services has been a continuing concern within the new arrangements and we are aware of current significant difficulties in relation to the re-couping of costs across the Welsh border.”*

**The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)<sup>32</sup>**

## The impact of tendering

The introduction of more competition in the provision of health services, as set out in the Health and Social Care Act 2012, has meant that it is now increasingly commonplace for local authority commissioners to put services out to tender.

*“Where collaborative commissioning has identified high quality provision of local services there should be no automatic requirement – indeed a strong disincentive – to enter a tendering process. Local authorities must be made aware that the process itself in such situations is very expensive of their own and the current NHS providers’ public money.”*

**British Association for Sexual Health and HIV (BASHH)<sup>33</sup>**

There are reasons why tendering of services can be beneficial to the commissioner and ultimately to service users. These include:

- The ability to control costs.
- The potential to drive up quality and outcomes.

Much of the evidence submitted to the inquiry expressed concern about the reality of putting services out to tender and the unintended consequences this has produced. Many responses stated that tendering and competition for services has led to fragmentation in the delivery of services, which is compounded by the issues set out in the previous section of this report.

*“While a small proportion of the 177 SRH doctors leading services in our survey cited positive experiences of tendering, over two thirds reported a negative impact on services as described above. A third also reported that “patient experience had worsened over the past year.”*

**Faculty of Sexual and Reproductive Healthcare<sup>34</sup>**

In some cases tendering can cause a breakdown of collaboration between providers, because they feel unable to share information and best practice as different providers are competing with each other. An example is where regional HIV care networks are developing, where hub and spoke relationships for complex inpatient care for HIV need to be developed. Members of a network may be in active competition for clinical sexual health services while attempting to build clinical and managerial collaborations in HIV care.

From a practical perspective, where procurement is short-term, services find it difficult to plan improvements as they may not retain contracts over the longer term and do not know if they will be delivering services in the future. This reduces the incentive to provide continuing training and development for staff and an incentive to only deliver services to the letter of the contract. This is clearly not an optimum position to be in from a staff retention and training perspective, which could create capacity pressures in services.

## Contracting

Where services are put out to tender, providers are reliant on local authorities writing a sufficiently good service specification to deliver improvements. Service specifications should follow a common national framework with national standards to maintain a consistent standard of care which should lead to less variation in public health across the country.

A comprehensive needs assessment should be undertaken before services are put out to tender to ensure that they are going to provide the right services for the locality and to provide local flexibility over and above a basic common standard. It would not be desirable for service specifications to be developed in isolation locally as this would see a vast range of services with different scopes all delivering different levels of quality. Once it is clear what needs to be included in the service specification, drawing on the common framework and the JSNA, this should be consulted upon by appropriate external sexual health, reproductive health and HIV experts.

Service specifications should include requirements for data collection, in order to assess how care pathways across the whole system are functioning and to help commissioners determine if the service is delivering a clinically useful and cost-effective service.

*“There isn’t a common or consistent approach to quality reporting apart from Annual Quality Accounts. A good process should be via a clear service specification and the performance monitoring data. CQC visits and checking whether services are meeting their outcome standards is supposed to check whether providers are meeting the quality required, but it isn’t clear how commissioners are then held to account.”*

**Brook<sup>35</sup>**

## Conclusion

Disparate funding streams being used by commissioners responsible for sexual health, reproductive health and HIV services have compounded concerns about fragmented service provision arising from different commissioning responsibilities. The absence of payment frameworks which enhance opportunities for commissioners to collaborate can limit efforts to deliver joined-up and innovative services. Mismatches in payment mechanisms which distort commissioning priorities need to be eliminated. Commissioners should be encouraged not only to work together to develop single funding mechanisms, but also to design contracts which meet local needs. Together, this has the potential to deliver efficiencies as well as continue to improve services which meet the evolving needs of local people.

## 10. Future funding

---

**Recommendation 6** – The public health ring-fence should be retained beyond 2016, and the Secretary of State should commit to protect the public health budget to ensure all aspects are funded, including prevention and clinical services.

---

**Recommendation 7** – Local authorities are mandated to commission confidential, open access services for STIs and contraception, but there is a need for clear guidance about what this means to ensure local authorities understand what they must commission. Based on the detailed explanation of mandated services, local authorities must be held to account over their spending of the public health budget. The Secretary of State should clarify which national body will hold local authorities to account for their spending.

The NHS Five Year Forward View contains a clear emphasis on the need for preventative services. It states *“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”*<sup>36</sup> This national level endorsement from Simon Stevens and NHS England about the vital role of public health is very welcome at a time when the perceived importance of activities badged as ‘public health’ are being downgraded.

### The public health ring-fence and proposed cuts to the public health budget

Services commissioned by local authorities are funded from the ring-fenced public health budget. This ring-fenced funding was welcomed as it provided some security that public health funding would not be lost to other priority areas identified by local councils. Sexual health accounts for about one quarter of local councils’ public health grant spend<sup>37</sup> but this in itself is not protected.

In June 2015, the Department of Health announced that it will consult on cutting £200 million from the public health budget in 2015/16<sup>38</sup>. This equates to over 7% of the overall public health budget. The Department has said that the NHS budget is protected, suggesting that cutting the public health budget will not impact on clinical services. This, however, is simply not true.

The £670 million currently allocated to sexual health within the ring-fence is for clinical services. In-year cuts equate to a loss of skilled staff, closure of clinics and potential loss of access to effective contraception resulting in more unintended pregnancies and transmission of STIs including HIV. If the total budget is cut it will be very hard for councils to protect the clinical budget within the ring-fence. This will therefore impact on the NHS.

## Monitoring local authority spending on public health

Compounding the impact of these potential cuts, evidence was presented to the inquiry stating that this ring-fenced budget is not always being spent by local authorities directly on public health services. A report by the BMJ<sup>39</sup> found that many local authorities have been diverting public health funds, including from sexual health services, to plug gaps in wider council services. This is an extremely concerning trend.

*“Despite benefiting from being ‘ring fenced’ public health monies are not being increased in 2015 and there is now evidence (for example from the work of the Advisory Group on Contraception) that ‘ring fencing’ is no guarantee of money being spent directly on public health services.”*

**Faculty of Sexual and Reproductive Healthcare<sup>40</sup>**

At present it does not appear that Public Health England, the Department of Health or the Department for Communities and Local Government are holding local authorities to account over their spending of public health funds. This means that it is very difficult to determine if the grant allocation is delivering good value for money for its intended purpose.

Based on the evidence presented, Public Health England should have a clear role in overseeing how money from the public health ring-fence is being spent and to feed back to, and where necessary, challenges local authorities on how the monies are being used.

In addition, it was identified that in the spending returns there was a small increase in spending on services, but a small decrease in spending on prevention<sup>41</sup>. The importance of prevention in STIs and HIV must not be underestimated in terms of delivering better outcomes and reducing upstream costs for the treatment of STIs and HIV. We would urge the Department of Health to extend the period of the ring-fence for public health when this is considered as part of the Spending Review in the autumn.

## Conclusion

The APPG firmly believes that this ring-fence must be extended beyond 2016 and, further, that additional guidance and oversight is required from Public Health England to support local authorities to purpose these funds appropriately. Having proper accountability structures in place and having clear sanctions for local authorities who do not spend the money for its intended purpose will help to embed sexual health, reproductive health and HIV commissioning in local government, ultimately reducing the risk that services worsen.

# 11. Workforce education and training

**Recommendation 8** – Health Education England should conduct a review and publish a report about future workforce needs in sexual health, reproductive health and HIV, setting out required service capacity, skill mix, under-graduate and post-graduate education and ongoing training needs. HEE should require that local education and training boards (LETBs) work with local authority and NHS commissioners and providers to ensure that a training and education needs assessment is conducted at the local level. Based on the needs assessment, training should be built into the service specification of contracts in order to protect time and funding for training and education.

Without an appropriately trained workforce and enough capacity generated by healthcare professionals with the right skills, access and choice in provision will become limited. Having enough healthcare professionals and ensuring they develop and maintain skills in sexual health, reproductive health and HIV services is of critical importance to delivering a high quality service for service users and patients.

## Workforce assessment and capacity

Delivering high quality sexual health, reproductive health and HIV services relies on a well-trained and flexible workforce, providing services in the right place at the right time to meet local need.

To achieve this aim it is important to know what the workforce looks like at present, in order to inform planning for the needs of the future. Evidence suggests that this type of workforce and training needs assessment is not happening in a systematic or routine way. To rectify this and to build a clearer picture of workforce capacity and capability, local education and training boards (LETBs) in each area should undertake a training needs assessment. This assessment should cover specialist services, general practice, the voluntary sector, the acute sector and community pharmacy as there is an ongoing need for a skilled workforce in all these areas.

*“Sex, lives and commissioning II” found that 86 councils (64 per cent) who responded to the audit, had not undertaken any assessment of whether there was a local need for additional contraceptive training to provide these contraceptive methods. We believe that commissioners should have arrangements in place to assess the training requirements of the local workforce to ensure there are enough healthcare professionals who are qualified to fit and remove subdermal implants and intrauterine contraceptive methods in order to meet local need. Where there is a need to increase the number of trained healthcare professionals, consideration should be given to how training can be made more easily accessible.”*

**Advisory Group on Contraception<sup>42</sup>**

In addition, data collection must be more clearly defined to include information about the current workforce and its level of training. As an example, evidence submitted by the Faculty of Sexual and Reproductive Health stated that *“it is not known how many GPs or nurses in primary care are trained to deliver LARC methods and their consequent availability to patients.”*<sup>43</sup>

We heard that there is little national direction on the development of the sexual health, reproductive health and HIV workforce. Therefore, in addition to the local assessments described above, Health Education England (HEE), as the national body tasked with leadership for the education and training system, should have a stronger role in ensuring that the shape and skills of the future sexual health, reproductive health and HIV workforce are able to evolve to sustain high quality outcomes for patients.

## Workforce education and training

Locally commissioned providers are responsible for ensuring that there are sufficient staff numbers to deliver the services and outcomes that have been commissioned. This should be detailed in service contracts and specifications. However, a number of people responding to the inquiry noted that tendering of services has impacted on the workforce because, in some instances, ongoing training is being reduced. This is because, in order to fulfil the requirements of the contract, continued professional development is not a pre-requisite. Education and training of the workforce must be viewed as a fundamental aspect of effective and sustainable health service planning and delivery, ensuring that patients continue to receive the highest standards of care. Commissioners have a responsibility to ensure that the service specification supports training needs. Ongoing education and training should therefore be a mandatory inclusion in provider contracts, often in the form of allocated study days for staff or funding to attend development programmes led by professional bodies.

For example, many GP practices face uncertainty about future funding of contraception service provision and will therefore not risk investing in training their staff. This potential shortfall in the number of trained healthcare professionals could pose a threat to the quality of reproductive health services in the future.

*“Seventy five to eighty percent of contraception in the UK is provided in primary care. In a recent survey of primary care clinicians, over 25% reported reduced funding for LARC in the past year and over 80% were unclear about funding for LARC fitting services for 2015 and beyond. These uncertainties have resulted in reduced demand and investment in training of GPs.”*

**Primary Care Women’s Health Forum<sup>44</sup>**

Services also have to train non-specialists – such as practice and school nurses – update GPs’ skills, and accept trainees from other specialties for short attachments (eg dermatology). These activities take time and pull expert staff away from frontline service delivery, but do offer whole system benefits. Similarly, general nursing students, undergraduate medical student clinical attachments, and formal teaching follow the same pattern. Contracting needs to take this educational function into account.

The strongest message which was highlighted in the evidence submitted to the inquiry was that at present it is unclear who should be commissioning and paying for education and training. It seems that this is largely being left to providers, but if there isn't additional money within contracts for ongoing training and development of staff, this isn't happening. Commissioners, working with LETBs, should make sure that there is some provision in contracts for ongoing training and development of professionals.

*“Current national accountability arrangements are not entirely clear. There have been some good pieces of work at a regional level in the South West which enabled areas to draw on regional funding to improve training in targeted areas such as LARCs and more recently the Integrated Nurse Training. It would be good to see these become more sustainable and to be offered more of these regionally driven opportunities to collaborate in order to improve common gaps in training. As GPs find it hard to access training, a more joined up approach nationally or regionally for this particular workforce would be welcome.”*

**South Gloucestershire Council<sup>45</sup>**

Contracts also need to build in time for innovation, by having the ability to release staff to do research to promote safe progress in medicine. For example, the PROUD study on pre-exposure prophylaxis in HIV was based in 13 GUM clinics in England and delivered world class results from clinical researchers. This type of work is unlikely to be possible unless local authority contracts are flexible enough to allow research time to be built in.

## Conclusion

Ensuring that the workforce is fit for purpose – in size, competency and continued training – is vital to ensuring that people receive the high quality care that they rightfully expect. Achieving this will require effective collaboration between commissioners, providers, professional organisations, LETBs and HEE to ensure that current and future needs are identified, planned for and embedded within training frameworks and provider contracts. This investment, in time and resource, has the potential to deliver significant benefits to the quality and outcomes of care that people receive, and to stimulate research and innovation.

## 12. School and population-wide education

**Recommendation 9** – The Department for Education should implement the recommendation of the Education Select Committee that sex and relationships education and PHSE should be made statutory subjects in all primary and secondary schools.

Earlier chapters have reviewed the oversight, infrastructure and funding of sexual health, reproductive health and HIV services. Getting these right is essential, but it must also be underpinned by steps to support a well-informed population which is prepared to openly talk about sexual health and equipped to make informed and responsible choices.

Sexual health does not get enough attention. This is partly down to the fact that people are embarrassed to talk about the subject, stopping people asking the questions they should be and meaning they are less likely to access services early, or complain if they experience a poor service. Changing attitudes and improving awareness and education about sexual health, reproductive health and HIV are therefore key ways of improving outcomes<sup>46,47</sup>. This can also play an important role in reducing demand on the system by encouraging early intervention and preventative action.

### Sex and relationships education in schools

Providing universal sex and relationships education (SRE) and PSHE in schools is the most efficient route to equip all children and young people to understand consent, stay safe from coercive and exploitative sex, and make positive and well informed choices about their sexual and reproductive health. However, despite the efforts of individual schools and local authorities, the quantity and quality of SRE remains seriously inadequate, with Ofsted verifying this to be a case in a third of all schools.<sup>48</sup> Children and young people themselves repeatedly describe the SRE they receive as “*too little, too late*”<sup>49</sup> and they feel that it is too biological. In a recent survey 27% of respondents described their SRE as bad or very bad and 25% reported that they had learned nothing about HIV and AIDS. It has been reported to the inquiry that there is insufficient time on school timetables allocated to the subject and no teacher training in many areas<sup>50</sup>.

The inquiry heard in a large proportion of the evidence that sex and relationships education should be made a statutory subject for all schools including academies and free schools. The inquiry recommends that the Government implements the February 2015 recommendation of the Education Select Committee that relationships and sex education and PHSE should be made statutory subjects in all primary and secondary schools.

*“It is absolutely essential for the public health system to link with the education system nationally and locally not just to promote good sexual and reproductive health, but also in the delivery of services and in the prevention of poor health. Central to this is statutory PSHE education (including SRE).”*

**Brook**<sup>51</sup>

Further, the inquiry recommends that an Inter-Ministerial Group is formed between the Department of Health, Home Office and the Department of Education so that adequate consideration is given to the health, wellbeing and safety aspects of education, providing a forum where formal discussions can take place between these departments to inform policy.

The Department of Health currently runs a survey of 15 year olds but this doesn't contain any questions about sexual health. A question about SRE would be an obvious way of monitoring progress in this area. In addition, local authorities should run an annual survey of young people to determine whether SRE is meeting their needs.

School nurses, in their public health roles, have huge potential to contribute very positively to SRE, providing one-to-one confidential sexual health, reproductive health and HIV support, and providing the bridge to local services. Sexual health and reproductive health is part of the Department of Health school nurse commissioning guide, but there is no drive to increase numbers and specific training in these areas. Therefore, more weight should be put behind this in order to ensure that the potential of this is realised.

There is a role for specific young people's sexual health services to work with schools and colleges, alongside school nursing teams. From a public health perspective, the links with education, children and young people's services, safeguarding and CSE agendas, youth and community services, Troubled Families, school nursing all sit under the local authority umbrella. It is therefore an advantage that public health and education are both located within local authorities.

*"It is an advantage that public health and education are both located within local authorities. We believe that sex and relationship education should be enshrined in the PSHE curriculum. The role of school nurses can be used to significant advantage in delivering chlamydia screening and other sexual healthcare to students."*

**British Association for Sexual Health and HIV (BASHH)<sup>52</sup>**

## Population-wide education

Promoting sexual health needs to take a life-course perspective. Therefore different approaches need to be taken for different populations, with tailored messages delivered through channels which will be most engaging to the specific groups.

*"NAT ... survey of over 1000 young men attracted to men. The findings showed that over a quarter (27%) of respondents did not know, or were not sure that 'HIV can only be passed on through semen, vaginal and rectal fluids, blood or breast milk'. Half did not know or were not sure that 'people living with HIV can live a normal life span if diagnosed in good time and on effective treatment.'"*

**National AIDS Trust (NAT)<sup>53</sup>**

Local authorities have commissioning responsibility for:

- Young people's sexual health services
- Outreach
- HIV prevention and sexual health promotion.
- Service publicity
- Services in schools and colleges
- Services in pharmacy

It is therefore essential that these services are invested in, to help with population-wide education about sexual health, reproductive health and HIV. As set out in the financial barriers section of this report, it has been brought to the attention of the inquiry that spending returns from public health have shown that spending on prevention has seen a small decrease. Given the impact that increasing awareness about sexual health, reproductive health and HIV can have on personal wellbeing and financial savings in service provision, retaining a focus on public awareness and education is important.

*"Promoting sexual health needs to take a lifelong perspective, and so this approach needs to be different for different populations, and can take many forms, from brief media-based campaigns to more detailed tailored interventions. All have a place in public health."*

**The British Psychological Society<sup>54</sup>**

## Conclusion

Increased awareness, from an early age, about good sexual and relationships health is essential in building an open and honest culture in which people are empowered to make informed and responsible decisions about their sexual health. Investment in public and childhood awareness is central to achieving the ambitions outlined in *The Framework* and can ultimately help drive person-led improvements in outcomes for sexual, reproductive and HIV services across the country.

# 13. Patient and user involvement

---

**Recommendation 10** – Patient and user involvement is key to ensuring that services are designed to be accessible to all those who require them, where and when they need to use them. Commissioners and providers need to involve the whole range of people accessing sexual health, reproductive health and HIV services, including those working and in good health, in the design and review of services.

Consumer involvement in health services is not a single, well-defined process and is practised in many different ways. If done badly or in the wrong way, consumer involvement may not lead to service or health improvement. It is a process that can have high visibility and has resource implications so getting it right is important.

Patient and user involvement usually refers to a consultative process the subject of which is usually predetermined by providers or commissioners of services, but there may be times where it is helpful to allow consumers to set the framework for consultation.

*“Feedback from service users is also important to ensure services provided are tailored to expectations of local communities.”*

**Wiltshire Council**<sup>55</sup>

The decision about who the users are is clearly an important one. Many general practices also have user groups to advise the practice on how it delivers services. Additionally, while it is not uncommon for HIV services to have visible user involvement and strong advocacy groups, nationally and sometimes also locally, the same cannot be said for users or potential users of STI and contraceptive services.

*“The Sexual Health Framework said commissioners should: ‘work in partnership with key players such as the local healthwatch, local advocacy groups, voluntary and community sector organisations and businesses to develop a joint commitment to improving local sexual health.’ We are one of the most active local patient voices in the area on sexual health, yet we have often found it difficult to get our voice heard, chiefly as a result of the transfer of public health from the NHS to local government.”*

**Women of Walthamstow**<sup>56</sup>

This lack of an established voice makes the need for effective and meaningful user involvement at a local level even more imperative.

A successful strategy is one that adopts a variety of engagement mechanisms. As such there is a need to recognise that consumer engagement and involvement mechanisms will be different depending on the local demographics and the need that is being considered.

Areas that may be covered include:

- Location of services.
- Opening times.
- Which services should be provided.
- Pathways into and out of services and links with other areas of healthcare. This might include pathways with general practice or gynaecological care.

*“... The current review of sexual health provision in Walthamstow ... is looking at developing a sexual health clinic in the central Walthamstow area with spokes in other parts of the borough ... We were the only direct service users there. It was a positive meeting. As a result we have publicised the council review via our Twitter feed (@wowstow) and passed the information to our local MP, Stella Creasy, who has publicised it through her weekly email to many Walthamstow residents. We have also offered to help organise an open public consultation meeting with the council. Had we not been involved, we doubt members of the public would have even been aware of the review.”*

**Women of Walthamstow<sup>57</sup>**

## Conclusion

Patient and consumer involvement in shaping sexual health, reproductive health and HIV services is very important in order to ensure that services are patient-centric and provide solutions to the things which service users value most highly. Consumer engagement is not static and should be sensitive to changes in local populations and risk groups. The consumer perspective should be visible and their views should be heard and considered by decision-making bodies.

# Annex 1 – Individuals providing oral evidence to the inquiry

- Professor Jane Anderson, Adviser on Sexual Health and HIV, Public Health England
- Dr David Asboe, Chair, British HIV Association (BHIVA)
- Dr Janet Atherton, President, Association of Directors of Public Health (ADPH)
- Dr Simon Barton, Chair, Clinical Reference Group for HIV, NHS England
- Toni Belfield, Specialist in Sexual Health Information
- Luciana Berger MP, Shadow Minister for Public Health
- Simon Blake OBE, former Chief Executive, Brook
- Dr Amanda Brittan, Honorary Secretary, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists (RCOG)
- Dr Jan Clarke, President, British Association for Sexual Health and HIV (BASHH)
- Dr Anne Connolly, Chair, Primary Care Women’s Health Forum (PCWHF)
- Andrea Duncan, Programme Manager, Sexual Health and HIV, Department of Health
- Jane Ellison MP, Parliamentary Under Secretary of State for Public Health
- Professor Kevin Fenton, Director of Health and Wellbeing, Public Health England
- Dr Kate Guthrie, Clinical Director, Sexual and Reproductive Healthcare Services, City Health Care Partnership CIC
- Dr Richard Ma, Member, Royal College of General Practitioners (RCGP) Sex, Drugs and HIV Task Group
- Tracey Masters, Consultant in Sexual and Reproductive Health, Homerton University Hospital NHS Foundation Trust
- Cllr Jonathan McShane, Community Wellbeing Board, The Local Government Association (LGA)
- Martin Murchie, President, Society of Sexual Health Advisers (SSHA)
- Dr Rak Nandwani, Chair, Genitourinary Medicine Specialist Advisory Committee, Joint Royal Colleges of Physicians’ Training Board
- Mark Rasburn, Chief Executive, Healthwatch Blackburn with Darwen
- Professor Wendy Reid, Director of Education and Quality, Medical Director, Health Education England (HEE)

- Colin Roberts, Nurse Representative, British Association for Sexual Health and HIV (BASHH)
- Jacqueline Routledge, Chair, English HIV and Sexual Health Commissioners Group
- Dr Audrey Simpson OBE, former Acting Chief Executive, Family Planning Association (FPA)
- Dr Ashish Sukthankar, Clinical Lead, Greater Manchester Sexual Health Network
- Neil Walbran, Chief Officer, Healthwatch Manchester
- Samuel Wallace, Borough Manager, Healthwatch Hammersmith and Fulham
- Dr Chris Wilkinson, President, Faculty of Sexual and Reproductive Health (FSRH)
- Matthew Winn, Chief Executive, Cambridgeshire Community Services NHS Trust

# Annex 2 – Terms of reference for the All-Party Parliamentary Group on Sexual and Reproductive Health inquiry into accountability and integration in sexual health, reproductive health and HIV services

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) has welcomed the ambitions of the Department of Health’s Sexual Health Improvement Framework and the vision it sets out for services in England.

Over the past year, the APPGSRH has had representation from a number of organisations about the good work being carried out – including by Public Health England, sexual health charities and professional bodies, commissioners and providers within the NHS – to deliver against the ambitions within *The Framework*, but we are also aware of ongoing areas of concern.

In particular, we are concerned about the current accountability arrangements within the new NHS and public health architecture and the lack of proper oversight over the quality and outcomes delivered by sexual health services. Accountability includes oversight of clinical governance arrangements; scrutiny of commissioning assessments and funding decisions; monitoring of national service standards; and identifying which organisation is responsible for ensuring services are properly integrated and that funding follows the individual, rather than integration being hampered by commissioning silos.

In response to these concerns, and in order to inform the ongoing debate about how *The Framework’s* ambitions can be achieved, the APPGSRH is launching an accountability inquiry looking closely at how the ambitions of *The Framework* can be better achieved.

A central objective of the Inquiry will be to make recommendations for how standards of sexual health services are to be monitored and improved, and to consider what the accountability framework should look like for this vital area of public health.

The APPGSRH's Inquiry will focus in particular on:

1. Assessing the statutory and commissioning architecture for sexual and reproductive health services and what the current accountability arrangements looks like. This will include an assessment of the role played by the following bodies within the architecture and consideration of what aspect of a high quality services they should be accountable for:

- Parliament
- Department of Health
- Public Health England
- NHS England (including its local area teams)
- Health Education England
- Care Quality Commission
- Monitor
- Sexual health networks
- Health and Wellbeing Boards
- Local Authorities, including Directors of Public Health
- Clinical Commissioning Groups
- Community providers
- General practice
- Sexual health professionals
- Service users

2. Inviting evidence from members of the sexual health community and others to assess what progress has been made in delivering against the core ambitions of the Department of Health's Sexual Health Improvement Framework, and identifying the accountable body within the new structures for achieving these improvements. Specifically:

- Rapid access to high quality services.
- Prioritise prevention by improving awareness of the causes of poor sexual health and encouraging safer behaviour.
- Reduce rates of STIs among people of all ages.
- Reduce onward transmission of HIV and avoidable deaths from it.
- Reduce unintended pregnancies among all women of fertile age.
- Continue to reduce the rate of under 16 and under 18 conceptions.

3. Making recommendations on how the policy, commissioning and provider arrangements can be improved to reduce variations in sexual health outcomes and setting out how the ambitions within the Sexual Health Improvement Framework can be implemented further.

The APPGSRH is seeking written evidence on the following matters:

- Under the new structural arrangements, which national organisation should be accountable for overseeing improvements in sexual and reproductive health services and that the ambitions in the Sexual Health Improvement Framework are delivered?
- At a local level which organisation do you believe should be responsible and accountable for overseeing improvements in sexual and reproductive health services?
- 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.
- 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?
- 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?
- How would you assess the current accountability arrangements for 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?
- What role should the public health system play in ensuring that education plays a role in promoting good sexual and reproductive health?
- 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?

Whilst this is an extensive list of issues the APPGSH wishes to explore, it is not intended to be exhaustive. Comments and recommendations on any other aspects of sexual and reproductive health services will also be welcome.

# Annex 3 – Full list of responsibilities by commissioner

Clinical commissioning groups	NHS England	Local authorities
<ul style="list-style-type: none"> <li>• Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services)</li> <li>• Female sterilisation</li> <li>• Vasectomy (male sterilisation)</li> <li>• Non-sexual health elements of psychosexual health services</li> <li>• Contraception primarily for gynaecological (non-contraceptive) purposes</li> <li>• HIV testing when clinically indicated in CCG-commissioned services (including A&amp;E and other hospital departments)</li> </ul>	<ul style="list-style-type: none"> <li>• Contraceptive services provided as an "additional service" under the GP contract</li> <li>• HIV treatment and care services for adults and children, and cost of all antiretroviral treatment</li> <li>• Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract</li> <li>• HIV testing when clinically indicated in other NHS England-commissioned services</li> <li>• All sexual health elements of healthcare in secure and detained settings</li> <li>• Sexual assault referral centres</li> <li>• Cervical screening in a range of settings</li> <li>• HPV immunisation programme</li> <li>• Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks</li> <li>• NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B</li> </ul>	<ul style="list-style-type: none"> <li>• Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts</li> <li>• Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV</li> <li>• Sexual health aspects of psychosexual counselling</li> <li>• Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacy</li> <li>• Social care services (for which funding sits outside the Public Health ring-fenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:             <ul style="list-style-type: none"> <li>• HIV social care</li> <li>• Wider support for teenage parents</li> </ul> </li> </ul>

## Annex 4 – References

- <sup>1</sup> Public Health England, Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, September 2014 (revised March 2015)
- <sup>2</sup> Department of Health, A Framework for Sexual Health Improvement in England, March 2013
- <sup>3</sup> Public Health England, Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, September 2014 (revised March 2015)
- <sup>4</sup> Written evidence from British Association for Sexual Health and HIV (BASHH)
- <sup>5</sup> Oral evidence from Jane Ellison MP, Parliamentary Under Secretary for Public Health
- <sup>6</sup> Written evidence from National AIDS Trust (NAT)
- <sup>7</sup> Derived from Public Health England, Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, September 2014 (revised March 2015)
- <sup>8</sup> Written evidence from the Care Quality Commission (CQC)
- <sup>9</sup> Written evidence from the Care Quality Commission (CQC)
- <sup>10</sup> Derived from Public Health England, Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, September 2014 (revised March 2015)
- <sup>11</sup> Written evidence from Terrence Higgins Trust (THT)
- <sup>12</sup> [http://www.local.gov.uk/health-and-wellbeing-boards/-/journal\\_content/56/10180/6111055/ARTICLE](http://www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE)
- <sup>13</sup> Written evidence from the Local Government Association (LGA) and Association of Directors of Public Health (ADPH)
- <sup>14</sup> Written evidence from the Local Government Association (LGA) and Association of Directors of Public Health (ADPH)
- <sup>15</sup> LGA and MEDFASH, Sexual health commissioning in local government: building strong relationships, meeting local needs, June 2015
- <sup>16</sup> Written evidence from The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)
- <sup>17</sup> Written evidence from MSD
- <sup>18</sup> Written evidence from the University of Bedfordshire
- <sup>19</sup> Written evidence from the Advisory Group on Contraception (AGC)
- <sup>20</sup> Written evidence from the Women of Walthamstow
- <sup>21</sup> Written evidence from the Local Government Association (LGA) and Association of Directors of Public Health (ADPH)
- <sup>22</sup> Written evidence from Bayer HealthCare
- <sup>23</sup> Written evidence from Angela Bussey, Royal Pharmaceutical Society representative (Sexual Health) and National PGD Website Specialist Pharmacist
- <sup>24</sup> Written evidence from the Advisory Group on Contraception (AGC)
- <sup>25</sup> Written evidence from Faculty of Sexual and Reproductive Healthcare (FSRH)
- <sup>26</sup> Public Health England, Public Health Outcomes Framework
- <sup>27</sup> Written evidence from the British Association for Sexual Health and HIV (BASHH)
- <sup>28</sup> Written evidence from Brook
- <sup>29</sup> Written evidence from The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)
- <sup>30</sup> Written evidence from Leeds City Council
- <sup>31</sup> Oral evidence from Dr Kate Guthrie, City Health Care Partnership
- <sup>32</sup> Written evidence from The Local Government Association (LGA) and Association of Directors of Public Health (ADPH)

- <sup>33</sup> Written evidence from the British Association for Sexual Health and HIV (BASHH)
- <sup>34</sup> Written evidence from Faculty of Sexual and Reproductive Healthcare (FSRH)
- <sup>35</sup> Written evidence from Brook
- <sup>36</sup> NHS England, Five Year Forward View, 2014
- <sup>37</sup> Department for Communities and Local Government, Local Government Financial Statistics No.24 2014, 2014
- <sup>38</sup> Health Sector Journal, 'Osborne announces £200m cut to public health budgets', June 2015
- <sup>39</sup> <http://www.bmj.com/content/348/bmj.g2274>
- <sup>40</sup> Written evidence from the Faculty of Sexual and Reproductive Healthcare (FSRH)
- <sup>41</sup> Department for Communities and Local Government, Local authority revenue expenditure and financing England: 2012 to 2013 individual local authority data, July 2013 and Department for Communities and Local Government, Local authority revenue expenditure and financing England:2013 to 2014 individual local authority data, July 2014
- <sup>42</sup> Written evidence from the Advisory Group on Contraception (AGC)
- <sup>43</sup> Written evidence from the Faculty of Sexual and Reproductive Health (FSRH)
- <sup>44</sup> Written evidence from Primary Care Women's Health Forum
- <sup>45</sup> Written evidence from South Gloucestershire Council
- <sup>46</sup> Oral evidence from Luciana Berger MP, Shadow Public Health Minister
- <sup>47</sup> Oral evidence from Simon Blake, former Chief Executive, Brook
- <sup>48</sup> Written evidence from the Family Planning Association (FPA)
- <sup>49</sup> Written evidence from the Family Planning Association (FPA)
- <sup>50</sup> Written evidence from the Family Planning Association (FPA)
- <sup>51</sup> Written evidence from Brook
- <sup>52</sup> Written evidence from the British Association for Sexual Health and HIV (BASHH)
- <sup>53</sup> Written evidence from the National AIDS Trust (NAT)
- <sup>54</sup> Written evidence from the British Psychological Society
- <sup>55</sup> Written evidence from Wiltshire Council
- <sup>56</sup> Written evidence from Women of Walthamstow
- <sup>57</sup> Written evidence from Women of Walthamstow

Bayer Healthcare has sponsored the formatting and printing of this report. Bayer Healthcare submitted written evidence to the inquiry but had no influence or involvement in the conduct of the inquiry or on the content of the inquiry report.



## **All-Party Parliamentary Group on Sexual and Reproductive Health in the UK**

**Chair: Baroness Gould, House of Lords, London SW1A 0PW.**

**Administration: FPA, 23-28 Penn Street, London N1 5DL**

**Tel: 020 7608 5258 / Email: [appg@fpa.org.uk](mailto:appg@fpa.org.uk)**