



All-Party Parliamentary Pro-Choice and Sexual Health Group

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Campaigning to raise awareness in parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK.

REPORT ON JOINT WORKING ON SEXUAL HEALTH AMONGST PCTS

2008

Supported by **fpa**, the Faculty of Sexual and Reproductive Healthcare and the British Association for Sexual Health and HIV.

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The purpose of the All-Party Parliamentary Pro-Choice and Sexual Health Group (APPG) is to raise awareness in Parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK. The Group was formed in 2003, when the All-Party Parliamentary Pro-Choice Group expanded its remit following the publication of the National Strategy for Sexual Health and HIV.

Introduction

The commissioning of wellbeing and prevention services to improve sexual health was declared to be a priority for all Primary Care Trusts by Lord Darzi, in his review of the NHS, *High Quality Care for All*, published in July 2008:

“Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, **improving sexual health and improving mental health.”¹**

Although the UK continues to have the highest rates of teenage pregnancies in Western Europe, they are now at their lowest levels for 20 years, and while rates of sexually transmitted infections do continue to rise, some of the increase will be due to improved access to testing. There has been a long term Government commitment to sexual health, since the publication of the National Strategy on Sexual Health and HIV in 2001, including the target to provide access to genito-urinary medicine (GUM) services within 48 hours, which was achieved in March 2008 as well as the roll-out of the national Chlamydia screening programme across England. Much has been achieved in improving sexual health services. However, there is a great deal still to do.

About this report

The APPG surveyed Primary Care Trusts (PCTs) in England between August and November 2008, to find out how they were prioritising sexual health as a key public health issue, to explore their key focus in commissioning services and also to determine their strategic partnerships with local government and other PCTs on sexual health services.

Survey Responses

Unfortunately, the APPG was hampered in providing a complete picture of sexual health in England by the disappointing number of responses to the survey. Despite several attempts to gather information between August and November

¹ High Quality Care For All – NHS Next Stage Review Final Report. Department of Health, page 9.

2008, only 89 PCTs responded to the survey, out of 152 PCTs (59 per cent). The poor response rate was both extremely disappointing and a matter of some concern as it is not clear what priority is attached to sexual health by those PCTs which did not respond.

However, there were responses from within all Strategic Health Authority (SHA) areas, and from both rural and urban areas. The findings of this report are based on the responses of the 59 per cent of PCTs which did respond to the APPG survey, except when the information about the priorities of all PCTs was in the public domain. We hope that the report provides a snapshot of how sexual health is being promoted

Given the APPG's experience in trying to contact PCTs, we recommend that PCTs should list a contact email address on their website. On the NHS landing page to their organisation, **30** PCTs do not give an email address, which impeded the APPG's communication with them. Two other PCTs listed the email address as firstname.lastname@pct.nhs.uk, which is unhelpful if the appropriate person's name is not also given. The APPG is concerned that the lack of email addresses reduces transparency as well as accessibility for PCT service users.

A copy of the survey can be found in Appendix 1, and a list of the PCTs which responded to the survey is provided in Appendix 2.

Summary of Recommendations

1. There should be a full time Commissioner for sexual health, with high-level, strategic responsibility, in each PCT.
2. All sexual health commissioners should be provided with accredited training and professional development on a regular basis.
3. PCTs should undertake a comprehensive sexual health needs assessment on a regular basis, so that service managers and commissioners are able to adapt their services to meet the needs of their communities.
4. All sexual health partnership boards should include the providers of services. The APPG also recommends that third sector organisations with an interest in sexual health which are not commissioned by the PCT to provide sexual health services, should be consulted on the strategic planning mechanisms of the PCT.
5. Networks between PCTs on sexual health should be encouraged, so that they can share information and good practice, as well as jointly commission services, when appropriate.
6. PCTs and local authorities should take a much more holistic approach to sexual health than just focusing on teenagers, and they should actively support men and women over the age of 18 to make good, and safe, sexual health choices.
7. All PCTs and Local Authorities should have a joint sexual health partnership board, or strategic group, to share information and help bring together service providers and commissioners from different agencies and sectors.
8. PCTs and Local Authorities should appoint a public health specialist to develop more systematic partnership working, and their remit should include sexual health.
9. PCTs and Local Authorities should work closely together to develop joint priorities on sexual health for the local area agreement and these priorities should be understood by all the relevant professionals in the organisations involved in achieving these priorities
10. More work is needed to support schools become Healthy Schools by 2009, and there should be better links between PCTs and schools to promote health and wellbeing.
11. All PCTs and Local Authorities should undertake Joint Strategic Needs Assessments of the sexual health needs of their local communities.

Part One: Sexual health as priority within PCTs

1. Is there a commissioner(s) within the PCT with full time responsibility for sexual health as their sole remit? If not, please give details about what proportion of their position is devoted to sexual health. Please give details about which strategic level this commissioner holds within the PCT.

Only 20 PCTs (22 per cent of those who responded to the survey) confirmed that they had a commissioner within the PCT with full time responsibility for sexual health. Three PCTs employed several commissioners who together made up the whole time equivalent (WTE) of a full time post. Three PCTs listed a full time commissioner to focus on teenage pregnancy, which may well support achievement of the government's target to reduce under-18 conception, but this does not demonstrate a holistic approach to commissioning sexual health services and leads to concerns about adequate access to sexual health services for people over the age of 20.

The remaining PCTs provided answers which demonstrated a range of time devoted to sexual health commissioning, from as little as 10 per cent of a commissioner's time to 80 per cent. Eight PCTs stated that they had no sexual health lead for commissioning. This was either because there was no-one in post, but funding was available and recruitment was underway; or because sexual health commissioning was part of more generic Public Health commissioning role but no breakdown of time spent specifically on sexual health was given. Most PCTs explained that their sexual health commissioner was a member of the Public Health or Health Improvement Directorates.

In response to subsequent questions, there was evidence of collaborative commissioning of some services, such as chlamydia screening, or two PCTs jointly funding a sexual health commissioner, which would be based in one PCT. In one London PCT, for example, the sexual health commissioner spent 30 per cent of their time commissioning sexual health services for their PCT, and the remaining 70 per cent of their time as the lead HIV commissioner for a consortium of eight PCTs.

Where seniority of the commissioner was given by PCTs, most tended to be Band 7 or Band, 8, especially those who were solely responsible for commissioning sexual health services. This level of seniority is welcomed and encouraged by the APPG.

However, from the responses received, the APPG is concerned that sexual health is not being given a high enough priority and that the absence of full-time sexual health commissioner in a majority of PCTs will have a detrimental effect on the commissioning of sexual health services. For example, in cases where there are several officials commissioning different aspects of sexual health services, without a senior lead official, there could be duplication of work and a lack of strategic direction. In addition, sexual health service users are usually not vocal about their needs, so a commissioner needs to devote a significant amount

of time to gathering high quality information, which can require specific skills and approaches. As commissioners within public health teams will be juggling issues such as smoking cessation and obesity as well as sexual health, there is a real concern that sexual health services could be neglected.

Recommendation 1: There should be a full time Commissioner for sexual health, with high-level, strategic responsibility, in each PCT.

2. Has the sexual health commissioner(s) received training about commissioning to support their role within the last 12 months? Please give details.

Commissioning sexual health services can be complex because a variety of different needs will have to be taken into account for a range of services including access to contraceptive services, abortion services, STI testing and treatment, HIV testing and treatment plus psychosexual and sexual dysfunction services. In addition all of these services can be provided in a range of settings including primary and secondary care as well as through outreach services. Furthermore the vast majority of the people who access these services will be unwilling to talk about their experiences or what they would like from the service so innovative means such as anonymous surveys have to be used to gather information about services users' opinion. All of this means that training for commissioners of sexual health services is vital.

There was a wide range of responses to this question. Thirty five PCTs had not provided training to their lead sexual health commissioner in the last twelve months. This is extremely disappointing. In addition, in some cases the reason given for not providing training was that the commissioner was new in post. The APPG is extremely concerned about this. New commissioners would benefit enormously from high quality training at the beginning of their employment, as would the local communities for whom they commission services.

Three PCTs did not respond to this question and five PCTs said that there was no need for training, given the long experience of their current commissioner, or that 'on the job' learning was provided. Two PCTs reported that their sexual health commissioners were completing post-graduate certificates in commissioning, and attending World Class Commissioning (WCC) scheme events, which is extremely welcome. However, it is extremely disappointing that these two PCTs were very much the exception rather than the norm.

In some cases there appeared to be confusion about whether commissioners had received training as some PCTs considered attendances at commissioning conferences or WCC events to be training while others mentioned these events but did not count them as training. There needs to be greater clarity for PCTs and commissioners as to what constitutes training to ensure that commissioners in different areas have comparable skills and competences.

More people are coming forward for STI testing, and the increased media focus on sexual health and awareness of long acting reversible methods of contraception (LARC) means that there is greater demand for sexual health services. It is vital that sexual health commissioners have excellent training to ensure they can identify and respond to the needs of their local populations.

Recommendation 2: All sexual health commissioners should be provided with accredited training and professional development on a regular basis.

3. Has the PCT done a sexual health needs assessment in the last 18 months?

The aim of this question was to find out how well PCTs knew their service users, and if the sexual health needs of their local community were kept under regular review.

Of the PCTs which responded to the survey, it is encouraging that 83 per cent had either performed a Sexual Health Needs Assessment or were in the process of completing one. Two PCTs had performed a needs assessment limited to young people's sexual health services, and another PCT had completed a needs assessment on HIV services only. A further 11 PCTs had not completed a sexual health needs assessment in the past 18 months.

It is vital that PCTs regularly undertake holistic sexual health needs assessment for their whole populations, not just for a particular age group or focused on a particular service. As has been noted previously, sexual health services users are often unwilling to talk about their experiences and so sexual health needs assessments provide important intelligence on which to base commissioning decisions. In addition, comprehensive needs assessments will identify not only those people who are currently using services but also those who do not currently access support and those who used to but no longer do so whose needs must also be taken into account when planning service delivery.

Recommendation 3: PCTs should undertake a comprehensive sexual health needs assessment on a regular basis, so that service managers and commissioners are able to adapt their services to meet the needs of their communities.

4. Please list the third sector providers involved, and how they feed into strategic planning mechanisms.

The APPG asked this question because third sector organisations are increasingly being commissioned to provide sexual health care services in primary care settings. In addition, many third sector providers have specialist knowledge and often have contact with people who are unwilling or unable to access mainstream services. Integrating their knowledge and expertise into the

strategic planning of the sexual health services in each PCT is therefore fundamental to improving the commissioning and provision of services.

PCTs which had completed a sexual health needs assessment tended to consult the voluntary sector providers from whom they commissioned services. Terrence Higgins Trust, BPAS, Brook, the Naz Project and **fpa**'s Speakeasy project were all listed as sexual health service providers.

In general a wide variety of other third sector organisations were listed by PCTs as having some level of involvement in sexual health service planning. These included:

- Barnardo's
- YWCA
- MIND
- Citizen's Advice Bureaux
- Local rape crisis organisations
- Positive Action
- LGBT groups
- BME organisations
- locally based organisations which supported teenage parents
- local organisations working with people with HIV/AIDS

In response to this question, PCTs provided less detail about **how** these organisations fed into the strategic planning mechanisms, but some PCTs did provide a description. One PCT described their strategy as follows:

"These organisations are all invited or sit on the sexual health partnership (board), which is responsible for delivering the needs assessment and monitoring progress on the Sexual Health strategy and commissioning plan. We are also holding a visioning event in November 2008 with all partners to gain feedback and engagement on how we actually implement the strategy on the ground."

Another PCT described the strategic involvement of the third sector in their areas as follows:

"All providers are members of PCT Sexual Health Modernisation Group meetings, Sector Meetings and [Regional] Sexual Health Board Meetings. The PCT's Sexual Health Modernisation group is the driving force behind the PCT's business planning for sexual health; therefore all partners can influence the delivery of sexual health services."

Recommendation 4: All sexual health partnership boards should include the providers of services. The APPG also recommends that third sector organisations with an interest in sexual health which are not commissioned by the PCT to provide sexual health services, should be consulted on the strategic planning mechanisms of the PCT.

5. The commissioning model should be holistic and look at sexual health in an integrated way, commissioning along the care pathway. Please outline below which agencies (within the Local Authority and in the wider community) are consulted when commissioning sexual health services.

PCTs' responses to this question were very similar to the answers given to the previous question. Reference was made to sexual health organisations such as Terrence Higgins Trust, Brook, BPAS, Marie Stopes and **fpa**. In addition, PCTs included a variety of local agencies in their responses such as:

- the Local Authority coterminous with the PCT
- local teenage pregnancy coordinators
- local schools
- Connexions
- youth groups and youth workers
- the local police service
- the children and young people's partnership,
- clinicians
- service users
- probation services
- foster carers and residential care staff
- youth offending teams
- drug and alcohol services

Although a wide variety of key local stakeholders is listed here the extent to which individual PCTs involved all of these partners varied. In addition, as with the responses to the previous question there was very little detail about how these partners were involved. Indeed, the majority of PCTs said that the sexual health steering group was the driving force for sexual health commissioning, so the agencies that were members of that group in a particular area were the ones who were most consulted.

6. Does the PCT have plans to enable the delivery of World Class Commissioning with respect to sexual health? Please give details.

There was broad support from PCTs either to meet each aspect of World Class Commissioning competencies in sexual health, or to improve commissioning delivery through the development of a clinical group structure along the lines of that used by Lord Darzi during his review of the NHS.

Thirteen PCTs said that sexual health was one of their World Class Commissioning priorities. A further 14 PCTs said that World Class Commissioning would be employed to help reduce rates of teenage pregnancy in their areas, and four PCTs hoped to improve chlamydia screening rates by the same approach.

Fifty PCTs said that although sexual health was not a specific World Class Commissioning priority, the commissioning framework was being used across the PCT to ensure long term and effective service provision, and that sexual health services would benefit from this. The commissioning of sexual health services remained under review for six PCTs, which mentioned restructuring in line with World Class Commissioning recommendations.

It was noticeable that PCTs were very focused on improving commissioning in line with Government targets, for example aiming to achieve reductions in the rate of under 18 conceptions by including teenage pregnancy rates as a health outcome metric that would be subject to assessment and review, for the purpose of World Class Commissioning assurance. Whilst this may be effective in reducing teenage pregnancy rates in these areas in the short term, the APPG recommend a more holistic approach is taken to sexual health over and above the areas which have been highlighted by Government targets to improve sexual health for all.

7. Is there any collaboration between your PCT and other local PCTs on sexual health commissioning? Please give details.

The APPG asked this question because information sharing can improve sexual health service delivery and it may also be economically beneficial to commission services jointly between PCTs, if the local areas have similar needs. There was an encouraging amount of formal and informal collaboration between PCTs on sexual health issues and sexual health commissioning. Of the 89 PCTs which responded to the survey only four said they did not have any collaboration with other PCTs, and one of these was in discussions. A further two PCTs did not respond to this question at all which means that the vast majority of PCTs are engaging with other PCTs to some extent on sexual health commissioning, albeit only informally in some cases. The most common services on which there was collaboration were chlamydia screening, HIV services and abortion services.

PCTs in London also listed measures such as joint condom purchasing between several PCTs, which is likely to save money for the NHS which can be devoted to other sexual health services. The APPG is encouraged by these examples of joint working amongst PCTs.

Increased collaboration was in evidence where a Sexual Health network was in place. Some of the networks already in existence cover SHA areas, such as in London while others focus on specific geographic areas such as Manchester, Cheshire and Merseyside. The APPG strongly supports the development of sexual health network. One PCT, said:

“We do not have any joint contracts with other PCTs but we do have links and contact with neighbouring PCTs in relation to sharing documentation and advice etc... I am hoping that [the SHA] may develop a network to allow this to happen on a more formal basis.”

Recommendation 5: Networks between PCTs on sexual health should be encouraged, so that they can share information and good practice, as well as jointly commission services, when appropriate.

Part Two: Collaboration with Local Authority on sexual health

1. Has the PCT, in collaboration with the Local Authority, highlighted sexual health as a local priority? Please give details.

Most PCTs demonstrated their joint working with the local authorities through Local Area Agreement targets, and this was almost universally focused on teenage pregnancy. Reducing the under 18 conception rate is a target to which PCTs seem committed and it has a significant impact on their sexual health service planning. Young people's services appear to be well resourced and with good links between PCTs and Local Authorities.

The responses placed less of an emphasis on extending chlamydia screening, which is extremely disappointing. Achieving widespread access to chlamydia screening is a central Government priority, and is vital given the prevalence and impact of undetected and untreated chlamydia. Some PCTs and Local Authorities are altering their focus from tackling teenage pregnancy rates to improving chlamydia screening, as they are making progress on achieving the target to reduce under 18 conceptions. However, the majority of PCTs continue to focus exclusively on teenage pregnancy, rather than looking at the sexual health needs of the entire community.

The APPG is concerned at this approach, as the sexual health needs of men and women over the age of twenty seem to be neglected. The group which experiences the highest rate of abortions are not teenagers, but women between 20 and 24, and STI rates for men and women over the age of forty are rapidly increasing.

Recommendation 6: PCTs and local authorities should take a much more holistic approach to sexual health than just focusing on teenagers, and they should actively support men and women over the age of 18 to make good, and safe, sexual health choices.

2. Does the PCT have a sexual health partnership board, including relevant service provider stakeholders for sexual health (in both primary and secondary care), as well as local authority representatives, representatives of education and social services, and sexual health promotion experts? Please give details about the composition of this board, and the frequency of meetings.

The APPG asked this question because we wanted to see if there were links in place between PCT based sexual health services and local authority services which would have an impact on sexual health. Knowledge of other organisations' work can help sexual health services to signpost service users to other agencies. Equally, it is helpful for social services, housing, and education bodies within the

Local Authority to consider sexual health as an issue when they are making decisions about their services.

According to the responses to the APPG survey, 79 PCTs have a sexual health partnership board, or strategic sexual health group, which is a joint endeavour between the PCT and Local Authority. Four of the PCTs said that their sexual health partnership group was primarily concerned with teenage pregnancy or young people's sexual health. Most of these groups tend to meet quarterly; in a couple of instances, some recently convened groups are meeting more often, either monthly or bi-monthly, and in one case, every two weeks.

Six PCTs said that they did not have such a group, although two PCTs were in the process of setting one up. Of these PCTs, one stated that they had disbanded their group as it was unproductive, but that quarterly meetings were held with the neighbouring PCT to discuss sexual health commissioning, which were much more productive. However, the APPG is concerned that this arrangement does not include other organisations, such as the local authority whose activities will have an impact on sexual health in the area. Where the partnership board is made up solely of PCTs there is likely to be an exclusively medical focus rather than including the perspectives of other agencies which could help to develop a more holistic approach.

Recommendation 7: All PCTs and Local Authorities should have a joint sexual health partnership board, or strategic group, to share information and help bring together service providers and commissioners from different agencies and sectors.

3. Has the PCT, in collaboration with the Local Authority, appointed a public health specialist to develop more systematic partnership working? Please give details about which strategic level they are at within the PCT.

Forty four PCTs indicated that the public health manager within the PCT fulfilled this role, and was jointly funded by the Local Authority. Two other PCTs were currently bidding for funding to create this position. A further 13 PCTs said that a similar role existed within their PCTs, but that it was not jointly funded.

Six other PCTs indicated that they had a position which was jointly funded by the PCT and the Local Authority, but the main responsibility of this position was reducing teenage pregnancy. The APPG was concerned that the exclusive focus on rates of under 18 conceptions meant that there was not a joined up approach to sexual health services in these areas.

Recommendation 8: PCTs and Local Authorities should appoint a public health specialist to develop more systematic partnership working, and their remit should include sexual health.

4. All Local Authorities (LA) are obliged to have a Local Area Agreement (LAA) in place, to set out the priorities for the area. Does your LA have a national indicator within its LAA on:

- a) the under-18 conception rate (NI 112)**
- b) the emotional health of children (NI 050)**
- c) the prevalence of chlamydia in under-25 year olds (NI 113)**

The APPG learned that information about the Local Area Agreement indicators is in the public domain², so the evidence gathered in this question from the 59 per cent of PCTs was cross-referenced against the information posted by the Department for Communities and Local Government.

On investigation, the APPG found some disparities between the local priorities listed by the Department for Communities and Local Government, and those listed by PCTs who completed the APPG survey.

Although the PCTs in London, for example, are broadly co-terminous with their local authorities by area and population, this is not necessarily the case across England. There are 152 PCTs, and 153 top-tier Local Authorities in England, but details about their boundaries are not easily accessible through Government websites. The disparities appeared in responses received from PCTs which are co-terminous with their local authority, and from PCTs which made up a smaller part of a top-tier local authority.

According to the Government statistics, there are 106 local areas which are targeting the under 18 conception rate as a LAA local priority. However, 20 PCTs, who were not listed on the 'Local Priorities' website as committed to this target, told the APPG that reducing the under 18 conception rate was one of the LAA national indicators which their PCT was prioritising.

Similarly, Government statistics, show six local areas are targeting the prevalence of chlamydia in under-25 year olds. However, an additional 28 PCTs also claim that this is one of the LAA national indicators which their PCT and Local Authority is prioritising in their responses to the APPG survey.

Furthermore, according to the Government statistics, 21 local areas are targeting the emotional health of children. However, according to the responses received by the APPG, an additional 29 PCTs are working with Local Authorities which claim to be prioritising the emotional health of children.

² Department for Communities and Local Government
<http://www.localpriorities.communities.gov.uk/>

The APPG has not been able to resolve fully the inconsistencies between the Government's data and the survey responses from PCTs. In some cases, it might be possible that a number of PCTs have submitted responses based on a single Local Area Agreement, which has resulted in some duplication. However, many PCTs do appear to be co-terminous with the local authority but have reported different answers to those we expected given the Government's statistics.

The APPG is concerned about this apparent confusion at a local level about what key targets people are working towards. We understand that there are a number of key indicators which people will be working towards in addition to the LAA, such as the NHS Vital Signs guidance. In addition, it may be that communication between PCTs and local authorities at all levels is not operating as well as it should and priorities across an area are not being shared.

Recommendation 9: PCTs and Local Authorities should work closely together to develop joint priorities on sexual health for the local area agreement and these priorities should be understood by all the relevant professionals in the organisations involved in achieving these priorities

5. If so, please outline below how this priority will be approached by the PCT and LA working in partnership.

The PCTs who had signed up to priorities on teenage pregnancies, chlamydia screening and the emotional health of children, asserted that they would be continuing their partnership work between the PCT and the local authority, and using the strategic sexual health meetings to promote these targets. Few details were given about how this would be carried forward, except that the stakeholders in these meetings, as commissioners, service providers and voluntary organisations involved in the meetings would be well-positioned strategically to continue the PCTs' and local authorities' work to improve the sexual health of their population.

6. One of the statutory priorities in the LAA is NI 072: Achievement of at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in Personal Social and Emotional Development and Communication Language and Literacy. Healthy school status will help achieve this priority. Please outline below what proportion of the schools in the PCT area have achieved healthy school status?

The Government has set a target that all schools will be participating in the National Healthy Schools Programme by 2009 and that 75 percent of schools will have achieved National Healthy School Status.

The APPG noted a wide range of responses to this question. Based on the response to the survey, the lowest percentage of healthy schools in an area was 33 per cent, and the highest was 98 per cent. This suggests that take up of healthy schools has been quite patchy across England.

In the survey, the APPG had asked what proportion of schools were engaged in the Healthy Schools Scheme as well as how many had achieved Healthy Schools status. This was aimed at finding out how many schools were working towards becoming Healthy Schools, as well as how many had achieved that benchmark. Only 13 PCTs responded to this question in full. Of those who did respond, all showed that at least 85 per cent of the schools in their areas were participating in the Scheme, which the APPG warmly welcomes, although we cannot assume that all other areas are achieving similar rates of engagement.

Four PCTs did not know, or were not able to find out, the percentage of schools in their area which had achieved Healthy School Status. The APPG is concerned that this is indicative of a lack of communication between PCTs and local authorities and/or education services. We strongly recommend that better channels of communications are developed between local agencies, particularly on initiatives such as the Healthy Schools Scheme which can have such an impact on young people's health and wellbeing. In addition, the APPG is hopeful that making Personal, Social and Health Education a statutory subject will improve schools' approach to health and wellbeing and have a positive impact on the health and emotional wellbeing of our young people.

Recommendation 10: More work is needed to support schools become Healthy Schools by 2009, and there should be better links between PCTs and schools to promote health and wellbeing.

7. Has a Joint Strategic Needs Assessment (JSNA) been a) commissioned and b) published on sexual health and HIV services within your PCT area?

The APPG was keen to find out whether PCTs and local authorities were jointly assessing the sexual health and HIV needs of their populations. This would have to be a more holistic assessment than a PCT-focused sexual health needs assessment, which would have primarily focused on clinical services. As management of services is increasingly being devolved away from central Government, it is important that there is communication and joint strategic decision-making at local level.

According to responses to the APPG survey, 24 PCTs have completed a Joint Strategic Needs Assessment (JSNA) with the Local Authority on sexual health and HIV services, and a further 37 PCTs have commissioned a JSNA on sexual health and HIV services, but these have not yet been published.

A further 13 PCTs told the APPG that their PCTs had commissioned and published a JSNA with the Local Authority on wider health and wellbeing issues, which incorporated aspects of sexual health and HIV services.

Although these responses were encouraging, inspecting the drafted and published copies of JSNAs which were sent to the APPG showed that sexual health usually only constituted a small part of a much wider health –focused document. The APPG is concerned that this could mean that some of the specific needs of services users, for example the using needs of people living with HIV, are not fully taken into account. While the APPG welcomes full JSNAs, we hope that PCTs and Local Authorities will complete wide-ranging JSNAs solely on sexual health and HIV services.

Recommendation 11: All PCTs and Local Authorities should undertake Joint Strategic Needs Assessments of the sexual health needs of their local communities.

Conclusions

The APPG recommends that all PCTs should have a full time sexual health commissioner at a high strategic level within the PCT.

The APPG recommends that all those officials who perform sexual health commissioning should be offered accredited training and professional development. While some PCTs are taking this forward, others are reliant on commissioners who have a long experience of commissioning, for whom training is seen as unnecessary. Given the changing nature of sexual health, with increased demand on sexual health services, and potentially a reduction in core funding for this area, training in commissioning sexual health services is vital.

The APPG was concerned, given the services which PCTs listed and the priorities which they highlighted in their responses, that contraception continues to be the poor relation in sexual health service provision. The PCTs which highlighted increased LARC commissioning were exceptions rather than the norm, despite additional funding and clear priorities from the Department of Health since early 2008. The APPG believes that a target on contraception would have a more direct impact on spending at PCT level. Improving access to the full range of contraceptive methods would also benefit PCTs, by reducing unintended pregnancies and therefore demand for abortion and maternity services, saving money in the longer term.

The APPG recommends that all PCTs and local authorities perform a specific joint strategic needs assessment on their population's sexual health.

The APPG notes that the emotional health of children and young people was identified as important, although more PCTs said it was a LAA key priority than is listed by the Department for Communities and Local Government. The APPG hopes that when PSHE is made statutory in the near future, emotional health will continue to remain a PCT and Local Authority priority. Continuing to focus on the Healthy Schools scheme and the emotional health of young people is crucial to ensuring that the quality of PSHE is improved and maintained.

The under 18 conception rate target is now a key priority for most PCTs. The APPG is concerned about how this work will continue after 2010 when the current strategy is due to come to an end. It is vital that work to reduce rates of teenage pregnancies is not abandoned with the end of the target. It is encouraging that some PCTs are aiming to achieve more than a 50 per cent reduction in under 18 conceptions by 2010, and that they regard teenage pregnancy as a key measure of inequality. The success which has been achieved to date must not be lost. Work to prevent teenage pregnancy must be continually renewed, for each new generation of young people.

**PCT Survey commissioned by
the All-Party Parliamentary Pro-Choice and Sexual
Health Group**

Name of Primary Care Trust:

Name:

Position:

Contact Email:

Local Authority area:

1. Sexual health as a priority within the PCT

Sexual health provision is a broad area, encompassing testing and treatment of sexually transmitted infections, specialised and non-specialised contraceptive services, abortion services, chlamydia screening, HIV/AIDS, teenage pregnancy, psychosexual problems, sexual dysfunction and sexual health promotion.

Please outline the range of sexual health services which are provided by the PCT, and give details about how widespread these services are throughout the PCT area.

1a. Sexual Health Commissioning

In his recent review of the NHS, Lord Darzi highlighted sexual health as a commissioning priority for all primary care trusts and councils.

- I. Is there a commissioner(s) within the PCT with full time responsibility for sexual health as their sole remit? If not, please give details about what proportion of their position is devoted to sexual health. Please

give details about which strategic level this commissioner holds within the PCT.

II. Has the sexual health commissioner(s) received training about commissioning to support their role within the last 12 months? Please give details.

III. Has the PCT done a sexual health needs assessment in the last 18 months? Yes / No

IV. Please list the third sector providers involved, and how they feed into strategic planning mechanisms.

- V. The commissioning model should be holistic and look at sexual health in an integrated way, commissioning along the care pathway. Please outline below which agencies (within the Local Authority and in the wider community) are consulted when commissioning sexual health services.

- VI. Does the PCT have plans to enable the delivery of World Class Commissioning with respect to sexual health? Please give details.

- VII. Is there any collaboration between your PCT and other local PCTs on sexual health commissioning? Please give details.

2. Collaboration with Local Authority on sexual health

- I. Has the PCT, in collaboration with the Local Authority, highlighted sexual health as a local priority? Please give details.

- II. Does the PCT have a sexual health partnership board, including relevant service provider stakeholders for sexual health (in both primary and secondary care), as well as local authority representatives, representatives of education and social services, and sexual health promotion experts? Please give details about the composition of this board, and the frequency of meetings.

- III. Has the PCT, in collaboration with the Local Authority, appointed a public health specialist to develop more systematic partnership working? Please give details about which strategic level they are at within the PCT.

(please answer overleaf)

IV. All Local Authorities (LA) are obliged to have a Local Area Agreement (LAA) in place, to set out the priorities for the area. Does your LA have a national indicator within its LAA on:

- a) the under-18 conception rate (NI 112) Yes / No
- b) the emotional health of children (NI 050) Yes / No
- c) the prevalence of chlamydia in under-25 year olds (NI 113) Yes / No

V. If so, please outline below how this priority will be approached by the PCT and LA working in partnership.

VI. One of the statutory priorities in the LAA is NI 072: Achievement of at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in Personal Social and Emotional Development and Communication Language and Literacy. Healthy school status will help achieve this priority. Please outline below what proportion of the schools in the PCT area have achieved healthy school status?

(please answer overleaf)

VII. Has a Joint Strategic Needs Assessment (JSNA) been a) commissioned and b) published on sexual health and HIV services within your PCT area?

a) Yes / No

b) Yes / No

VIII. If so, please send us a copy.

Please complete this survey by **30 September 2008** and return to:

Rachel Stewart
fpa
50 Featherstone Street
London
EC1Y 8QU.

For further enquiries, please contact Rachel Stewart on 020 7608 5258 or rachels@fpa.org.uk

Appendix 2 – PCTs which responded to the APPG survey

Ashton, Leigh and Wigan PCT	North East Lincolnshire Care Trust
Barking and Dagenham PCT	North Lancashire PCT
Barnet PCT	North Somerset PCT
Bassetlaw PCT	North Staffordshire PCT
Bedfordshire PCT	North Tyneside PCT
Bexley Care Trust	Northamptonshire PCT
Blackpool PCT	Northumberland Care Trust
Bolton PCT	Nottinghamshire County PCT
Bournemouth and Poole PCT	Oldham PCT
Bradford and Airedale PCT	Oxfordshire PCT
Brighton and Hove City PCT	Peterborough PCT
Bristol PCT	Plymouth PCT
Bromley PCT	Redbridge PCT
Buckinghamshire PCT	Rotherham PCT
Bury PCT	Salford PCT
Calderdale PCT	Sandwell PCT
Cambridgeshire PCT	Shropshire County PCT
Central Lancashire PCT	Solihull Care Trust
Cornwall and Isles of Scilly PCT	Somerset PCT
County Durham PCT	South Birmingham PCT
Coventry PCT	South Gloucestershire PCT
Cumbria PCT	South Tyneside PCT
Darlington PCT	South West Essex PCT
Derby City PCT	Southampton City PCT
Devon PCT	Southwark PCT
East Lancashire PCT	Stockport PCT
East Riding of Yorkshire PCT	Stoke-on-Trent PCT
Enfield PCT	Sunderland PCT
Gateshead PCT	Surrey PCT
Halton and St Helens PCT	Swindon PCT
Hammersmith and Fulham PCT	Tameside and Glossop PCT
Haringey PCT	Telford and Wrekin PCT
Havering PCT	Torbay Care Trust
Heywood, Middleton and Rochdale PCT	Trafford PCT
Hillingdon PCT	Wakefield District PCT
Hounslow PCT	Waltham Forest PCT
Isle of Wight PCT	Wandsworth PCT
Kensington and Chelsea PCT	Warrington PCT
Leicester City PCT	Warwickshire PCT
Lewisham PCT	West Sussex PCT
Lincolnshire Teaching PCT	Western Cheshire PCT
Manchester PCT	Westminster PCT
NHS Norfolk	Wirral PCT
North East Essex PCT	Wolverhampton City PCT
	Worcestershire PCT