Breaking down the barriers:
The need for accountability and integration in sexual health, reproductive health and HIV services in England

Executive Summary
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.
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.