Written evidence submitted by the APPG on Sexual and Reproductive Health
(PHP0005)

About

The APPG on Sexual and Reproductive Health aims 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 APPG’s Secretariat is supported by the sexual health charity FPA, the Faculty of Sexual and Reproductive Healthcare (FSRH) and the British Association for Sexual Health and HIV (BASHH).

To find out more about the APPG please visit: www.fpa.org.uk/appgsrh

Introduction and summary

The APPG welcomes the Health Select Committee’s decision to launch an inquiry on the impact of the Health and Social Care Act 2012 (‘the Act’) on public health post-2013. Sexual, reproductive health and HIV services were some of the areas most impacted by structural changes to the way in which services are commissioned and subsequently delivered. When responsibility for public health was first transferred to local authorities, the APPG began to hear that changes were leading to fragmentation in commissioning and service provision, while creating silos in formerly integrated areas of public health.

As such, the APPG conducted its own inquiry in June 2015, with witnesses including the Parliamentary Under Secretary of State for Health and senior representatives from the Care Quality Commission and Public Health England. Following a review of the evidence presented, the APPG published Breaking Down the Barriers: The Need for Accountability and Integration in Sexual Health, Reproductive Health and HIV Services in England. Our response focuses on these findings, covering:

- the impact of a lack of accountability and fragmented commissioning on the delivery of services
- the ability of local authorities to effectively deliver sexual and reproductive health services
- spending on sexual and reproductive health, and the potential impact of short term cuts in on long term spend for the NHS
- the lack of oversight on the sexual and reproductive health workforce capacity and capability

We hope that the evidence supplied in this response will be useful and informative, and guide the Select Committee to use sexual and reproductive health as a case study. We would welcome the opportunity to provide further evidence if called upon.

Background

The Health and Social Care Act 2012 made significant changes to the way in which sexual and reproductive health and HIV services are delivered. Since April 2013, local authorities assumed responsibility for public health, with the aim of bringing commissioning closer to the requirements of local populations. Although the objectives behind the reforms are welcome, in reality it has created an incredibly complex commissioning landscape, as detailed below:

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1 Breaking Down the Barriers (APPGSRH, 2015)
Local authorities commission comprehensive sexual health services, including: contraception and all prescribing costs (while excluding contraception provided under the GP contract); sexually transmitted infection (STI) treatment, including chlamydia screening and HIV testing; sexual health aspects of psychosexual counselling; and any specialist sexual health services, such as young people’s sexual health services, HIV prevention and sexual health services in schools, colleges and pharmacies.

Clinical commissioning groups (CCGs) commission: abortion services; sterilisation (both tubal occlusion and vasectomy); and non-sexual health elements of the psychosexual health services and gynaecology, including any use of contraceptives for non-contraceptive purposes.

The NHS England Commissioning Board commission: contraception services under the GP contract; HIV treatment and care; HIV testing when required in other NHS England commissioned services; STI testing and treatment as provided under the GP contract; cervical screening and the HPV immunisation programme.

Current Public Health England (PHE) statistics\(^2\) show that there are now record numbers of sexually transmitted infections (STIs) diagnosed among men who have sex with men (MSM) and incidences of syphilis and gonorrhoea are at their highest level in 30 years. At the same time, a survey conducted by the Faculty of Sexual and Reproductive Health (FSRH) in 2015 found that one-third of leading sexual and reproductive health doctors reported that “patient experience had worsened over the past year.”\(^3\) As such, it is clear that it is increasingly important that sexual health services are prioritised by all agencies involved in commissioning and that public health is protected from spending cuts.

The delivery of public health functions

The APPG’s inquiry found that, across the reorganisation of the NHS, a common theme has been a distinct lack of clarity in identifying who is ultimately responsible at a national level for sexual health, reproductive health and HIV services, hampering the ability of any agency to drive up outcomes across the country. In her oral evidence, Parliamentary Under Secretary of State for Public Health Jane Ellison MP stated that, “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.”

However, there appear to be limited mechanisms for the Secretary of State and the Department of Health to push for improvement, and there is no clear way (or obligation for) national bodies to intervene over poor performance in local commissioning. This lack of oversight is leading to a number of examples of where divisions in the system are creating challenges and unintended consequences for commissioners, providers and service users, some of which are detailed below.

Money is not following the patient, with women experiencing restrictions in access to a full range of contraceptive methods. This could be because contraception is commissioned both by local authorities and NHS England (under the GP contract), while abortion services are commissioned by clinical commissioning groups (CCGs). Although finances are not the sole consideration in commissioning decisions, it is clear that if local authorities invest in preventative contraception, savings later down the line would benefit CCGs.

\(^2\) Sexually transmitted infections (STIs): annual data tables (PHE, 2015)

\(^3\) Written evidence to Breaking Down the Barriers (APPGSRH, 2015)
• **Commissioning is being duplicated**, which is also limiting access. For example, contraception for gynaecological and non-gynaecological purposes are being commissioned by two different bodies, which means that women accessing contraception for gynaecological purposes need to go to a hospital, rather than a community clinic offering the same method for contraceptive purposes. This is a key example of a commissioning silo, which does not fully recognise the needs of the service-user.

• **Disruption of the patient pathway** means that sexually transmitted infection (STI) testing and contraception is not always available to women when they have had an abortion.

• **Physical separation of formerly integrated services** is occurring, as STI services have been relocated away from acute trusts where HIV treatment is delivered. These services were a key point of contact for people living with HIV and could potentially reduce the quality of care they receive. If an HIV caseload is quite small, the splitting of STI services could also render the HIV service unviable, if there is not a great enough patient caseload.

**The effectiveness of local authorities in delivering the envisaged improvements to public health**

*Delivering a whole-system approach*

It was a key ambition of healthcare reforms that local commissioners and provider organisations could overcome ‘back office’ distinctions. In some areas, this is being realised, with tailored approaches being implemented to the advantage of local communities. The Local Government Authority (LGA) and Medical Foundation for HIV and Sexual Health (MEDFASH) produced a document\(^4\) in June 2015, highlighting nine case studies that demonstrate effective working, including:

- the use of a Section 75 agreement to allow Norfolk County Council and NHS England’s East of England Specialised Commissioning Team to jointly commissioned an integrated sexual health and HIV service for the county; and
- a collaboration between Warwickshire County Council and the NHS on the Respect Yourself programme to promote sexual health and wellbeing for 13-25 year olds.

Although there are a number of examples of good practice, it is clear that local authorities are not meeting their mandate to provide confidential, open access services across the board.\(^5\) This can partially be explained by commissioners’ lack of ability to work in collaboration with partners to create a whole-system approach. In written evidence to the APPG, the LGA and the Association of Directors of Public Health (ADPH) stated that “the artificial distinctions between HIV and STI treatment and split of HIV prevention responsibilities between local authorities, CCGs and NHS England has made it important that sexual health commissioners work the ‘whole system.’” Although the LGA has taken a leading role in supporting this transition, commissioners need greater support to deliver coordinated services provision.

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\(^4\) **Sexual Health Commissioning in Local Government** (LGA and MEDFASH, 2015)

\(^5\) **Commissioning Sexual Health Services and Interventions: Best Practice for Local Authorities** (Department of Health, 2013)
Effective use of funding

Disparate funding streams have further compounded concerns about the efficacy of service provision arising from disjointed commissioning. Structural change has led to a situation where there is an absence of payment frameworks that encourage commissioners to work jointly, while mismatches in payment mechanisms distort commissioning priorities.

For example, the introduction of the Act's competition clauses has led to an increase in tendering. Although tendering can be beneficial (due to the potential to control costs and drive up quality), there is evidence of it causing a breakdown in collaboration between providers. Unwillingness to share best practice can be explained at least in part by the fact that providers are competing for contracts. From a practical perspective, where procurement is short term, services also find it difficult to plan for the future, which is to the detriment of staff retention and training.

Changes in payment mechanisms have also meant that many local authorities can now choose to commission services either through block contracts (which pay a fixed sum of money to provide a service set out in a specification) or by tariffs (which allow service providers to be paid by the activity delivered). This has resulted in some areas where GUM is commissioned on tariff and sexual health and reproductive services on block contracts, which can distort services provision and access in a way unrelated to need.

Monitoring the needs of local people

There is also concern about the ability of local authorities to plan for the needs of their local areas. Research conducted by the Advisory Group on Contraception (AGC) found that 31% of local authorities had never carried out a needs assessment of their contraceptive services and did not have one planned. Without collecting this data, it is not possible for local authorities to understand the needs that exist across their local area.

This issue is supported by evidence in some areas of restrictions for women seeking contraception services based on age, place and type of contraception. The AGC further illustrated this, when they reported to the APPG that, in an audit of commissioners in England, they found that over 3.2 million women of reproductive age (15-44) were living in areas where fully comprehensive services are restricted. This clearly puts at risk the progress made since 2003 in reducing rates of teenage pregnancy.

The public health workforce

Alongside the disregard for training arising from the short term procurement practices mentioned above, evidence collected by the APPG suggests that assessments of training needs for the sexual and reproductive health workforce are not happening in a systematic or routine way.

Local providers are responsible for ensuring that there are sufficient staff numbers to deliver the services and outcomes that have been commissioned, although evidence submitted to APPG made it seem as through training is largely being left to providers. However, there is no requirement to include resources for training when local authorities commission services.

Public health spending

In June 2015, the Government announced plans to cut £200 million from the public health budget, which local authorities will have to implement by January 2016. Although the

6 Written evidence to *Breaking Down the Barriers* (APPGSRH, 2015)
Department of Health has stated that there will not be an impact on clinical services, this is clearly not the case. In-year cuts equate to the loss of skilled staff, closure of clinics and potential loss of access for effective contraception, resulting in more unintended pregnancies and increasing transmission of sexually transmitted infections (STIs), including HIV.

The long term costs of reductions is spending on public health interventions and prevention has recently been demonstrated by the sexual health charity FPA. *Unprotected Nation 2015: An Update on the Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services* was released by the charity ahead of the Spending Review, using a hypothetical reduced spending scenario of 10% in order to establish the possible future cost to the NHS. The report found a false economy of ‘savings’, with the reduced spending scenario potentially resulting in:

- an additional £8.3 billion spending on the outcomes of unintended pregnancies (both direct health costs and non-health associated costs, for example education) over the next five years
- an extra 72,299 sexually transmitted infection diagnoses by 2020, at a cost of £363 million. This includes almost 20,000 additional cases of gonorrhoea, at a time when fears about antibiotic resistance of the bacterial infection are being realised.

Based only on the in-year £200 million cut to public health spending, FPA’s findings show that if spending decreases become the norm over the next five years, every £1 considered a saving in sexual and reproductive health could actually cost £86.

**Local authority spending**

Compounding the impact of these potential cuts, a British Medical Journal (BMJ) investigation in March 2014 found that many local authorities have been diverting public health funds to plug gaps in wider council services, such as housing and social care. This is especially concerning as, at present, it does not appear that Public Health England (PHE), the Department of Health or the Department of Communities and Local Government are able to hold local authorities to account over their public health spend.

**Recommendations and concluding remarks**

Prior to the new commissioning structure taking hold in April 2013, the Department of Health produced *A Framework for Sexual Health Improvement in England*, which outlines the need for joined-up working, coordination and innovation from commissioners and providers in delivering the Act’s aims for patients. The APPG agreed with the aims set out in the document, but considers it important to note that it was an exercise in ambition, as it did not set out any key commitments from the Department relating to accountability or include a plan to monitor progress made towards achieving the *Framework*’s aims. The APPG’s inquiry revealed persistent challenges, particularly regarding the leadership, expertise and accountability needed to ensure the delivery of a consistent and effective service.

In order to meet the aims set out in the *Framework*, the APPG made a number of recommendations, which we hope the Select Committee will consider:

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8 *Raiding the public health budget* (BMJ, 2014) [http://www.bmj.com/content/348/bmj.g2274](http://www.bmj.com/content/348/bmj.g2274)

• There must be a clarification in the accountability for the delivery of sexual, reproductive health and HIV services. The Department for Health, as a steward of the system, must monitor and challenge each of these national bodies.

• The Department of Health should require that Directors of Public Health, working with health and wellbeing boards, scrutinise local commissioning decisions. The Department of Health should also set out an indicator to monitor and measure the progress of the Framework for Sexual Health Improvement in England.

• A new standard contract should be put in place which sets out minimum standards for providers. Before services are put out to tender, a thorough needs assessment should be undertaken to determine the requirements of the local population. Contracts should also ensure that the same funding mechanisms are used across services, to reduce distortions in delivery.

• There should be no additional cuts to public health made in the Spending Review and the Secretary of State should commit to protect the public health budget to protect both prevention and clinical services.

• Local authorities should be held to account with their spending, and the Secretary of State should clarify which national body should be responsible for this. There also needs to be clear guidance in order that local authorities can understand their mandate to commission confidential, open access services for sexually transmitted infections (STIs) and contraception.

• Health Education England (HEE) should conduct a review into the needs of the future sexual and reproductive health and HIV workforce. Local Education and Training Boards (LETBs) should be required by HEE to work with local authority and NHS commissioners to ensure that training needs assessments are conducted at a local level. Based on these assessments, training requirements should be built into contracts.

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