Written evidence from the LGA submission

1. About the Local Government Association (LGA)

1.1. The LGA is the national voice of local government. We work with councils to support, promote and improve local government.

1.2. We are a politically led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

1.3. We welcome the opportunity to respond to the Health and Social Care Committee’s inquiry into sexual and reproductive health.

2. Summary

2.4. The success of sexual and reproductive health services depends on everyone working together to make these services responsive, relevant, easy to use and ultimately to improve the nation’s health.

2.5. A whole system approach should be adopted at both the local and national levels covering prevention, improvement, promotion and protection, spanning the three areas of sexual health, HIV and reproductive health. Attempts to tackle these issues in isolation will lead to silo working and will lead to poorer outcomes for peoples’ sexual health.

2.6. Record demand for sexual health services is putting considerable pressure on commissioners and providers.

2.7. The £533 million reduction by central government to the public health grant in local government by 2020 is a short-term approach. It will only compound acute pressures for the NHS and other services.

2.8. We are pleased to see that the overall prevalence of sexually transmitted infections remain stable. However the continued increases in rates of syphilis and gonorrhoea seen in the UK and internationally remains a concern. It is also unacceptable that there continue to be persistent inequalities in sexual health outcomes particularly amongst young people, black ethnic minorities (BME) and gay men. This is why central government, local authorities and other partners need to continue to work together in order to improve public health outcomes.

3. Trends

3.9. The overall number of new STI diagnoses in England fell slightly from 423,352 in 2016 to 422,147 in 2017. There were however increases in some specific conditions, whilst other conditions saw a decrease. Some key indicators are set out below:

3.9.1. The total number of sexual health screens (tests for chlamydia, gonorrhoea, syphilis and HIV) increased by 18 per cent, from 1,513,288 in 2013 to 1,778,306 in 2017

3.9.2. 7,137 diagnoses of syphilis reported in 2017 – this is a 20 per cent increase on 2016 and a 148 per cent increase since 2008
3.9.3. 44,676 diagnoses of gonorrhoea reported in 2017 – this represents a 22 per cent increase on 2016, which is of concern given the recent emergence of extensively drug resistant Neisseria gonorrhoeae

3.9.4. 441 diagnoses of first episode genital warts in 15 to 17 year old girls in 2017 – this is a 90 per cent decrease since 2009; this decrease is largely due to the high coverage National HPV Immunisation Programme in school-aged girls

3.9.5. More than 1.3 million chlamydia tests were carried out and more than 126,000 chlamydia diagnoses were made among young people aged 15 to 24

3.10. Although diagnoses of sexually transmitted infections (STIs) have continued to fall overall, latest data suggests progress is in danger of stalling at a time when sexual health services are now at a worrying tipping point due to wider funding constraints within local government. This means that any further improvements will be extremely challenging to achieve.

3.11. STIs and unplanned pregnancy are amongst the biggest contributors to poor health, particularly in the most deprived neighbourhoods in the UK. There have been consistent falls in teenage pregnancies in recent years, due to the application of successful strategies. These include education, support and access to comprehensive sexual health services. The under 18s conception rate in England in 2016 was 21 conceptions per 1000 women aged 15-17. This is the lowest rate since the statistics were first recorded in 1969.

3.12. The progress made in supporting people with HIV, enabling them to live independent, fulfilling lives and the fact that it is no longer the death sentence it once was is a major public health success story. We do, however, accept that none of us should be complacent.

3.13. Chlamydia testing in some settings has decreased. This could be a sign that the deliberate strategy of Directors of Public Health has proved successful, particularly in concentrating chlamydia testing on people more likely to be positive, rather than blanket testing whole populations. We are continuing to monitor chlamydia screening activity and while overall screening rates have fallen, the increase in positive tests suggests that the more targeted approach is working.

3.14. Local Commissioners recognise that investment in prevention has the potential to pay dividends. For example, when considering total cost savings across the public sector (including both healthcare and non-healthcare cost savings), there is an £9 saving for every £1 invested in publicly provided contraception.

3.15. **LGA recommendation:** Public Health England (PHE) to develop a strategy to achieve a year-on-year decrease in incidence, a reduction in health inequalities, and ultimately the elimination of syphilis and gonorrhoea in England. To achieve these ambitions and deliver significant improvements, the strategy should set out the improvements that need to be made and the actions that are required to achieve these improvements.

4. **Funding**

4.16. Councils invest more than £600 million a year in sexual, reproductive and HIV services. This is not just because it is cost effective in saving money in the long term, but because it significantly improves peoples’ general health and wellbeing. Only drug and alcohol services, children’s 0-5 and public health services have higher council allocated funding.

4.17. Councils currently face cuts to their public health budgets of £531 million by 2019/20. This has made it a significant challenge for them to respond at the scale needed. Government cuts to councils’ public health budgets has left local authorities struggling to meet increased demand for sexual health services.
4.18. There is no time for complacency. Unless greater recognition and funding is given to councils to invest in prevention services, a reversal in the encouraging and continuing fall in some STIs is now a real risk. Health inequalities will remain and councils may be unable to respond effectively to unforeseen outbreaks.

4.19. Local authorities are engaged in one of the biggest modernisation exercises in the history of public health, forced by reductions to the public health grant and local authority funding more generally. But the ability for local authorities to innovate and increase efficiency is nearing its end.

4.20. Below is a table highlighting the fall in local authority spending on sexual health services. At the same time, the number of people attending sexual health clinics has increased.

<table>
<thead>
<tr>
<th>Sexual Health Services</th>
<th>2016-17</th>
<th>2015-16</th>
<th>2014-15</th>
<th>2013-14</th>
<th>TOTAL All Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000’s</td>
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<tr>
<td>Sexual health services - Contraception (prescribed functions)</td>
<td>£171,064</td>
<td>£194,846</td>
<td>£190,699</td>
<td>£178,606</td>
<td>£735,214</td>
</tr>
<tr>
<td>Sexual health services - Promotion, prevention and advice (non-prescribed functions)</td>
<td>£52,423</td>
<td>£70,184</td>
<td>£69,196</td>
<td>£68,531</td>
<td>£260,333</td>
</tr>
<tr>
<td>Sexual health services - STI testing and treatment (prescribed functions)</td>
<td>£374,241</td>
<td>£369,374</td>
<td>£396,221</td>
<td>£397,788</td>
<td>£1,537,624</td>
</tr>
<tr>
<td>National Total</td>
<td>£597,728</td>
<td>£634,403</td>
<td>£656,116</td>
<td>£644,925</td>
<td>£2,533,172</td>
</tr>
</tbody>
</table>

Source: LAPHG Drilldown Tool 2016-17 RO – 16-11-17 Final Published

4.21. **LGA recommendation:** Investment in public health must be increased. Reductions to public health budgets must be reversed and public health needs to be funded both sustainably and adequately in line with local population health need.

5. Demand

5.22. Latest figures show there were 3,323,275 attendances at sexual health clinics in England in 2017, up 13 per cent on the 2,940,779 attendances in 2013.

5.23. While it is good to see more people are taking responsibility for their sexual health, the rise in the number of people attending sexual health clinics is placing a significant strain on councils’ resources. Councils are concerned that this will see waiting times start to increase and patient’s experience deteriorate. Priority will be given to those with symptoms (or a diagnosis) to be seen new in clinic. It is important to meet the needs of local populations proportionately, whilst prioritising those with diagnosed needs.

5.24. The total number of sexual health screens (tests for chlamydia, gonorrhoea, syphilis and HIV) has risen 18 per cent during this time period, from 1,513,288 in 2013 to 1,778,306 in 2017.

5.25. Attendance figures at sexual health clinics in England:

5.25.1. 3,323,275 attendances in 2017
5.25.2. 3,227,254 attendances in 2016
5.25.3. 3,140,492 attendances in 2015
5.25.4. 3,100,928 attendances in 2014
5.25.5. 2,940,779 attendances in 2013
5.26. See Annex A for graphs which explain this in more detail.

5.27. Commissioners often highlight the challenge of meeting rising demand within constrained resources. Approaches to addressing this include the economies of scale and greater negotiating power of a larger commissioning footprint, developing self-management options and increased prioritisation of prevention in service specifications. Engaging clinicians in finding solutions and ensuring the voices of service users are heard in developing strategies, planning and delivering major change are vital.

6. Adopting a whole systems approach to sexual health

6.28. A whole systems approach needs to be taken at both the local and national levels covering prevention, improvement, promotion and protection and spanning the three areas of sexual health, HIV and reproductive health.

6.29. Wherever commissioning responsibilities lie, Sexual and Reproductive Health (SRH) and HIV will always be complex and fascinating areas of public health and healthcare with clear links to other areas such as education, maternity services and the justice system. Whatever the national legislative framework, or local arrangements, there will always be a need to work collaboratively.

6.30. There has never been a greater need for public services to work together at a local level, pooling expertise and resources in a collaborative, whole system approach. In doing so the inter-related SRH and HIV health needs of service users across primary and secondary care, and between secondary care specialties are recognised and put at the heart of the commissioning process. It is important to recognise collaborative commissioning arrangements will not be driven centrally, but must be established locally.

6.31. Service users’ needs for integrated pathways are at the heart of the case for collaborative whole-system commissioning. Following an HIV diagnosis, for example, it is essential to refer the patient to specialised services for a rapid assessment of viral load to decide whether antiretroviral (ARV) treatment should be initiated. Or following provision of emergency contraception, access to advice and provision of the full range of ongoing contraceptive methods, including long-acting reversible contraception (LARC), is important.

6.32. Poorly connected care means a risk of patients falling out of the system which can, for example, reduce their treatment adherence. Disjointed pathways also mean opportunities may be missed to address the individual’s wider needs, whether they relate to drug and alcohol use or domestic abuse, for example.

6.33. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS) provide an opportunity to take a whole systems approach to sexual health and work more closely together to create a more coordinated service for patients. This will provide links into pathways for services such as early pregnancy assessment, abortion services and health visiting.

6.34. Local authorities are well placed to commission and deliver a positive approach to sexual health. Through the range of services they provide including, early years and youth services, local authorities can develop integrated sexual health strategies. Alongside, services to address the other key determinants of health and wellbeing, such as alcohol and drug misuse, smoking, obesity, mental health and violence (particularly violence against women and girls), they can work effectively towards reducing health inequalities.

6.35. Strong Director of Public Health system leadership, detailed needs assessment and an evidence base for action, clear problem definition and transparency in developing solutions in partnership are required. It is also recognised that engagement must be formalised to respect procurement procedures at certain points in the commissioning process.

6.36. Identifying and managing risks and jointly tracking progress in improving outcomes are the hallmarks of strong local relationships between commissioners and providers. These are an
7. Transformation in sexual health

7.37. Local authorities are working with their providers to develop new and modern ways to deliver patient care, in ways that are more convenient and better fit patient lifestyles. (Some interesting examples are annexed at the end of this briefing)

7.38. Councils are responding to demand pressures by commissioning more services that wrap around the needs of the user. Examples of this expansion include:

- 7.38.1. provision of 6 day rather than 5 day services in some places
- 7.38.2. 24 hour online booking
- 7.38.3. home testing and home sampling services
- 7.38.4. early and late opening
- 7.38.5. delivering more responsive services close to places live and work
- 7.38.6. shifting services out of poor quality accommodation

7.39. Given the age profile of sexual health service users, there is great potential to maximise the use of advanced health technologies and social media in service development to deliver outcomes at a lower cost.

8. Treatment and Prevention

8.40. Sexual health services account for over 25 per cent of the entire public health expenditure of English local councils. However, only a small proportion of this expenditure is on prevention. It is important that well-funded and coordinated public health programmes are put in place however, we must also strengthen the existing programmes which are focused on helping people improve their sexual health.

8.41. Health outcomes for individuals can be improved through integrated care pathways and preventative interventions targeting those most at risk. Preventative strategies such as integrating genitourinary medicine (GUM), HIV and contraceptive services can help to reduce the incidence of STI contraction and transmission and promote contraceptive choice in those accessing services.

8.42. Sexual health programmes should not just be about treating illness but also about building resilience and preventing future harm through education and health promotion. Sexual health promotion work should help people to make informed choices and should address the prejudice, stigma and discrimination that can be linked to sexual ill health. Improving the quality of individuals’ sexual experiences is important and can be achieved through ensuring that there is high quality education, good access to sexual health services, and effective preventative programmes.

8.43. The use of social media, apps and other forms of media are increasingly being used to provide clear and consistent messaging around contraception, STIs, wider health issues and how to access services. Media campaigns can be targeted to high risk groups and can help to normalise conversations, promote behaviour change (for example, the use of contraception) and encourage people to take responsibility for their sexual health.

8.44. LGA recommendations:
8.44.1. Sexual health commissioning and services should embrace the introduction of evidence-based innovative technologies and digital services, which can increase capacity and address barriers to screening.

8.44.2. Action should be taken to put into place effective preventative strategies such as integrating genitourinary medicine (GUM), HIV and contraceptive services to reduce the incidence of STI contraction and promote contraceptive choice.

8.44.3. Sexual and reproductive education should be coupled with timely access to confidential advice and dedicated young peoples’ contraceptive services.

9. Commissioning of sexual health services

9.45. Commissioning responsibilities for HIV, sexual and reproductive health have undergone major changes in recent years. These changes bring both opportunities and challenges. There has been the opportunity to build upon the successes of recent years and take a fresh look at problems where we have made less progress.

9.46. Redesign in many areas has focused on integration – integration with other services, such as criminal justice, adult services, children and young people and integration across the wider health economy.

9.47. Developing self-management options, increased prioritisation of prevention in service specifications, engaging clinicians in finding solutions and ensuring the voices of service users are heard, strong system leadership and an evidence base for action are all critical success factors.

9.48. The Association Directors of Public Health (ADPH) and PHE recently published *Sexual Health, Reproductive Health and HIV: A Review of Commissioning*, which identifies the commissioning challenges faced by commissioners and providers. These range from tackling sexual and reproductive health and HIV in a co-owned strategic way to managing the complexities of multi commissioners dealing with open access services. The fragmentation and division of commissioning responsibilities is leading to services being commissioned in new silos built around the commissioning structures and not service users.

9.49. The recommendations outlined in the report need to be fully implemented. At the national level, this will involve revising current commissioning guidance, facilitating sexual health networks, developing a framework for sector-led improvement (SLI) for sexual health and enhancing commissioning support tools. At the local level implementation, this will involve developing a model of ‘lead integrated commissioning’ in each locality and testing models of local delivery based on local practice.

9.50. It is important that CCGs, local authorities and the NHSE work closely together to ensure that care and treatment is high quality and not fragmented. Provision must be joined up to enable seamless patient journeys across both sexual health services and other health services, including HIV and antenatal care services.

9.51. Sharing commissioning responsibility along the sexual health and HIV pathway provides a number of opportunities to address the holistic needs of people living with HIV and the wider public health agenda. As well as potential benefits, there are also some challenges. Without a collaborative approach between NHS England, local authorities and CCGs, there are concerns that the sustainability of HIV care and treatment services could be at risk.

9.52. The commissioning, planning and delivery of services should focus on delivering better sexual health outcomes across a breadth of settings and interventional approaches. It is imperative that outcomes for sexual health services cover effectiveness, safety and individual experience of care. Individuals will have diverse needs which will vary by factors such as age, gender and disability. It is important that the commissioning, planning and delivery of services caters for the needs of people of all genders and sexual orientation and at all life stages.
9.53. Residents and service users should be at the centre of co-designing services and be part of continuous feedback to and from service providers. Effective commissioning must address health inequalities and tackle the stigma associated with STIs and diseases such as HIV. The person centred and rights-based approach needs to be balanced with the responsibilities of commissioners and planners to meet needs, promote prevention and balance budgets.

9.54. The engagement of political leaders in developing new sexual health models and expanding the role of services to address wider priorities such as child sexual exploitation and domestic violence and abuse is striking. It is also noteworthy how much commissioners have benefitted from local government procurement and legal expertise. This has enabled them to grasp the opportunities of specific procurement approaches, such as Competitive Dialogue and the Negotiated Procedure, to engage providers in shaping service models to meet specifications. Legal mechanisms such as Sections 75 and 76 have enabled joint commissioning to the benefit of patients who will experience more integrated care.

9.55. There have been some calls from sub-sections of the public health world (substance misuse, sexual health, smoking cessation) for their services to be returned to the NHS. We believe this is misguided given that the state of NHS finances means it is unlikely public health would be any more protected. Local authorities are having to address challenges that the NHS would not or could not do prior to the 2012 reforms.

9.56. Analysis of council commissioning data demonstrate better outcomes for service users\(^\text{ix}\). Local authorities are having to prioritise, they have significantly less to spend and some of them will prioritise different things based on the needs of their population.

9.57. There are several national reports\(^\text{xv}\) that show local government has been successful delivering services under difficult circumstances and has prioritised, as well as innovated. We have had more transparency and the sector has been challenged, rightly by those that access our services.

9.58. **LGA recommendations:**

9.58.1. There is need for a life course approach to sexual and reproductive health that is person centred and that integrates physical, mental and emotional wellbeing.

9.58.2. A radical upgrade towards integrated services; such as an opportunity to meet unidentified/unmet contraceptive needs in those presenting with STIs.

9.58.3. PHE to support local commissioners with new service specs promoting key sexual and reproductive health outputs/outcomes e.g long-acting reversible contraception (LARC) prescribing.

9.58.4. PHE, British Association for Sexual health and HIV (BASHH), NHS England, British HIV Association (BHIVA), Faculty of Sexual and Reproductive Health (FSRH), LGA to share and encourage positive examples of system join up/collaboration, and use of specialist professional expertise to support service redesign.

9.58.5. The recommendations of the *Sexual Health, Reproductive Health and HIV: A Review of Commissioning report* need to be fully implemented.

9.58.6. All sexual health commissioners and service planners should address health inequalities and cultural and behavioural influences on health choices such as the stigma associated with sexually transmitted infections and diseases, such as HIV.

9.58.7. There is a role for local scrutiny of the commissioning and delivery arrangements for sexual health, reproductive health and contraceptive services and the outcomes from those services for local people and communities. This could be a role for health overview and scrutiny committees within local authorities, providing added assurance alongside local system oversight through health and wellbeing boards.
10. Sex and Relationship Education

10.59. Children and young people who receive comprehensive, high quality RSE (Reproductive and Sexual Education) are more likely to delay the first time they have sex, have consensual relationships, be aware of and report abuse, use contraception when they start a sexual relationship and be less likely to be pregnant by 18 or contract a sexually transmitted infection. Understandably, schools have an important role to play in helping children and young people learn about positive relationships and educating them about wider issues. Teachers can be a regular point of contact for children and young people, so they are in a good position to identify trends in behaviour and take action if needed.

10.60. Children also learn about the importance of healthy relationships in schools, both as part of the curriculum and in the school environment. Conversations inside and outside the classroom can help children to recognise potentially abusive behaviours, identify trusted adults who they can talk to and receive information about support services. It is a good opportunity to help raise awareness within schools of the warning signs/risk indicators of criminal exploitation.

10.61. We are pleased that the Government has responded positively to our calls to make Relationships and Sex Education, a compulsory school subject, delivered as part of the broader PSHE Programme.

10.62. However, we are also conscious that some parents may wish to remove their children from this, which is why we are saying there should also be provision for parents to opt their children out of lessons, if they consider this to be in the best interests of their child.

10.63. RSE also extends beyond the classroom. Whilst the majority of young people want to learn about RSE at school, we know that they also want to be able to talk to their parents and health professionals, such as school nurses, or sexual health services about sex and relationships too. Councils have a vital role to play in joining up their commissioning of these existing services with what is taught in schools and in wider settings outside of the classroom. For example, in Leicestershire the anonymous and confidential service ChatHealth, delivered by public health school nurses, allows young people to ask questions about their sexual health and wider health which they may be too embarrassed to ask in RSE lessons. It is therefore, vital that local authorities work with all schools in their area to influence and commission consistent good quality RSE as part of their responsibilities to improve public health outcomes for children, young people and families.

10.64. We are concerned that the number of STI diagnoses rocket once people have left school, with 141,060 new diagnoses for 20 to 24-year-olds in 2015, compared with 78,066 for those aged 15 to 19.

10.65. The LGA, PHE and the Sex Education Forum produced a briefing for local authorities on the role councillors can play in supporting RSE.

11. Pre-exposure prophylaxis (PrEP)

11.66. We fully support PrEP being made available to everyone who needs it and are working with PHE and NHS England to launch a national programme following the trial period and subsequent evaluation to avoid any delay in national roll-out. Taking steps to halt the spread of HIV is of paramount importance to us and PrEP is a vital tool for doing this. Earlier this year, the PrEP Oversight Board agreed that the workstream on preparing for future commissioning should be brought forward a year, with work now underway with regard to this.

11.67. The aim of the trial, which has ethical approval, is not to meet all need but to collect data to address and reduce the uncertainties that face public sector commissioners in their decisions about future investment in a large scale programme.

11.68. The trial is planned to last three years and we are pleased to see a considerable amount of interest shown with 13,000 participants at high risk of acquiring HIV.
11.69. However, it is important that the findings of the clinical trial are examined before the national roll out of the programme, in order to learn more about the uptake of PrEP. We are particularly interested in understanding whether particular groups including women, BME groups and the youngest men who have sex with men (MSM) are accessing PrEP. We also need to examine other issues such as whether the use of PrEP brings an increase in other STIs and the knock on effect of potential system pressures.

11.70. It is also essential that the issue of financial implications of a national roll out on local commissioners is considered as part of any national roll out of the programme.
Annex A – Demand in local authority services between 2013 and 2017 (as referred to on pg.4)

Diagram 1: Number of attendances at sexual health services between 2013 to 2017

Diagram 2: Number of new attendances during the same period
Annex B  - Local authority case studies

These case studies highlight local government success of commissioning sexual health services since taking over this responsibility in April 2013.

From a mix of urban and rural settings, they illustrate commissioners acting on a range of sexual health priorities to meet rising demand with tightening resources, expanding the role of sexual health services to address the broader needs of vulnerable young people, redesigning services in large cities to deliver a new model of care, integrating HIV and sexual health services to avoid fragmentation and maintain service viability, and updating HIV prevention approaches.

In Norfolk, the local authority and NHS England came together to commission jointly by developing the first Section 75 agreement for HIV and sexual health services in England. Following a sexual health needs assessment undertaken by the Public Health department in 2013, the two organisations came together and agreed to commission through a Section 75 (S.75) agreement. This approach was considered to be the ‘best match for Norfolk’. It was the first such agreement for commissioning sexual health and HIV services between a local authority and NHS England and was developed to address the risk of service fragmentation in the post-Health and Social Care Act commissioning landscape. Having agreed to commission jointly, the local authority took the lead in the procurement process through a Competitive Dialogue based on Lean principles. All parties were satisfied the process was well matched to the development of the new integrated sexual health service with a hub and spokes model.

The London HIV Prevention Programme (LHPP) was established by the London Directors in Public Health in 2013 following a London wide needs assessment. London Councils, the cross party umbrella organisation for London’s 32 local authorities and the City of London, played an important role in ensuring the programme was not ‘lost’ at the time of transition. In February 2013, London local authorities, recognising HIV as an important public health issue, moved at pace to commission a needs assessment and review the evidence for the continuation (or otherwise) of the programme. Council leaders agreed a new programme, with significantly reduced funding compared with previous years, for a minimum of three years to 2017.

Warwickshire County Council pioneered the innovative ‘Respect Yourself’ (RY) programme to promote sexual health and wellbeing for 13-25 year olds. The programme provides young people with the power to make confident, positive and informed decisions about their relationships and sexual health by building knowledge and self-esteem. A website and smartphone application were developed through a series of residential workshops and training designed by and with young people. The programme also commissions training and provides data analysis and other resources for organisations working with young people. The RY programme was initially developed in partnership with the NHS by a sexual health commissioner jointly employed by local government and the NHS, prior to the transfer of public health. Since the transfer, partnerships have also developed with the children’s and community safety departments, the council’s lead officers on domestic abuse and substance misuse, the police and crime commissioner, and the police.

In tackling teenage pregnancy, Cornwall Council has taken a holistic approach. Whether it is the way relationships and sex education (RSE) is delivered to how parents, young people and the children’s workforce are supported, the local authority has ensured no stone has been left unturned as it has driven down the under 18 conception rate by 60 per cent since 1998. At the heart of the programme is strong leadership and accountability. There is a Sexual Health Commissioning Board of senior local leaders, which oversees a sexual health partnership group, composed of front-line representatives and strategic leads from all the main partners. Together they monitor local data, take charge of evaluating projects, carry out consultations with young people and their families and ensure clear approaches to communication are taken.

Leicestershire County Council school nursing service has set up a text messaging service for secondary school pupils. It has helped the service engage hard-to-reach groups with pupils reporting it makes them feel more comfortable discussing sensitive issues such as contraception, body image and sexual partners.
London Borough of Newham commissions a specialist Female Genital Mutilation Prevention Service. The borough identified the need to work with at risk communities to increase reporting for support (voluntary or statutory support) and the need for greater understanding among professionals in supporting FGM victims.

Integrated sexual health services and HIV treatment and care in Hampshire are now commissioned by three local authorities, seven CCGs and the NHS England Area Team. The model includes HIV outpatient care, STI testing and treatment, contraception, abortion, vasectomy, psychosexual counselling, chlamydia screening and sexual health promotion services plus a training and network management function for community pharmacies and GPs. Outreach clinics in Further Education (FE) colleges and an outreach referral service for vulnerable young people are also provided. £1m was saved in the first year of operation.

Six local authorities in Berkshire (Slough, Reading, Bracknell Forest, West Berkshire, Royal Borough of Windsor & Maidenhead and Wokingham Borough Councils) established a legal agreement to share resources to commission sexual and reproductive health services. A jointly appointed Director of Public Health for Berkshire leads a shared team. The key commissioning aims are to ensure equity of access for service users and an efficient use of public health resources. The approach is based on pooling resources, concentrating expertise and developing a county wide approach. It also facilitates liaison with the commissioners of HIV treatment and care and abortion services.

Darlington has a multi-agency teenage pregnancy and sexual health steering group. The group’s work feeds into commissioning of sexual health services and also involves a wider professional stakeholder network. The Director of Public Health chairs the steering group which is coordinated by a member of the public health commissioning team. Membership of the group is broad including local authority children’s commissioners and service leads, sexual health services, midwifery, health visiting, academies, colleges and voluntary sector organisations. A number of organisations, including the CCG and NHS England area team, are part of the wider professional stakeholder network.

Blackpool Council set up its “Positive Steps into Work” in 2007 which works across local government to support People Living with HIV to find employment. The delivery team are experienced in working with diverse clients with complex needs. Working in partnership with public health, the service has developed a dedicated employment adviser post exclusively to support clients from the Council funded substance misuse service (Recovery Centre) and HIV support programme (Sexual Health HIV Education and Response-SHIVER).

The English Sexual Health and HIV Commissioners Group (ESHHCG) shares experience and disseminates knowledge. The ESHHCG is a commissioner only network, which reduces the isolation of the sexual health commissioner role, highlights good practice, enhances national consistency and helps maintain the profile of sexual and reproductive health and HIV. Its work supports the development of collaborative commissioning to promote high quality and cost-effective local decision-making.

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6 LAPHG Drilldown Tool 2016-17 RO – 16-11-17 Final Published
7 Local authority revenue expenditure and financing report, MHCLG (2017).
viii Public health grants to local authorities: 2018 to 2019, DHSC (2017)
ix Sexually transmitted infections (STIs): annual data tables (PHE)
x Making it work: a guide to whole system commissioning for sexual and reproductive health and HIV
xi Local authority revenue expenditure and financing report, MHCLG (2017).
xii Sexual Health, Reproductive Health and HIV: a review of commissioning, PHE (2017)
xiii Making it work: a guide to whole system commissioning, PHE, 2014
xiv Public Health England’s grant to local authorities, NAO
xv Public health post-2013 inquiry, Health Select Committee (2016)
xvi Pearce, J. (2009) Young People and Sexual Exploitation: It’s not hidden, you just aren’t looking
xviii Resources for councillors on supporting Relationship sex education (RSE)
https://www.local.gov.uk/resources-councillors-supporting-relationship-sex-education-rse
xix Making it work: a guide to whole system commissioning, PHE, 2014,
xx Sexual health commissioning in local government: building strong relationships, meeting local needs.