APPG Sexual and Reproductive Health Accountability and Performance Review 16 October 2014

About the LGA

The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.

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.

In total, 415 authorities are members of the LGA. These members include 351 English councils, the 22 Welsh councils via the Welsh LGA, 31 fire authorities, 10 national parks via corporate membership and one town council.

About the ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. www.adph.org.uk

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities, government and other sectors.

Directors of Public Health (DsPH) across the UK are the frontline leaders of public health, working across health improvement, health protection, and health care service planning & commissioning.

Sexual Health Services in Local Government

The transfer of local public health responsibilities from primary care trusts (PCTs) to local government, coupled with the creation of Health and Wellbeing Boards has seen one of the most significant changes to the health and wellbeing landscape in a generation.

Through their Directors of Public Health and the Health and Wellbeing Board, local authorities have grasped this opportunity to redesign their commissioning and provision of services and in so doing make them more cost efficient and deliver

better outcomes.

Local government is ideally positioned to think more broadly about sexual health services and, working with partners, ensure they evolve to meet the needs of their population. Redesign in many areas has focused on integration – integration with other services, such as housing, criminal justice, adult services, leisure, children and young people and integration across the wider health economy.

We know that rapid, open access to high-quality integrated genitourinary medicine (GUM) and sexual health services, together with improved choices for people's reproductive health, have an enormous impact on individual and population health and wellbeing.

We also recognise that we should never be complacent. Rates of new, late and undiagnosed HIV infection remain high, abortion rates reflect unmet contraception needs, and rates of sexually transmitted infections are on the increase.

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

In particular, public health teams in local government have tried to ensure that HIV commissioning is linked effectively with local sexual health service commissioning but this has proved challenging with a complex commissioning system.

Sexual health services account for over 25% (£682m) of the entire public health expenditure of local councils. There are also high levels of mobility across local authority boundaries so it is imperative that as a sector we work together to co-ordinate and integrate provision but also to control spending.

The challenges faced within the sexual health community are not new and they were certainly present pre-transition. Councils report that in some areas they inherited from their PCT huge geographical inequities, lack of service for some communities and poor facilities needing modernisation.

We know there has been both excitement and anxiety around the transfer of public health to local government. People working in sexual health have probably expressed more anxiety than most. While there were real risks, there has also been opportunity to build upon the successes of recent years and take a fresh look at problems where we have made less progress.

1. Under the new structural arrangements, which national organisation/s should be accountable for overseeing improvements in sexual and reproductive health services and that the ambitions in the Sexual Health Improvement Framework are delivered? Why do you think this?

The Department of Health (DH) has a clear role regarding accountabilities for

overseeing improvements in sexual and reproductive health services and meeting the ambitions set out in the Sexual Health Improvement Framework. DH should have an overarching assurance role, partly because they are accountable for CCG's and NHS England, but also to ensure that national standards are adhered to.

Given the complexity with the system it is useful to set the national and local commissioning context i.e. that Local Authorities, CCGs and NHS England should be held accountable for overseeing improvements as they all commission services relevant to sexual and reproductive health. This accountability should relate to the services that each organisation directly delivers but also how they demonstrate joint collaborative approaches to commissioning across pathways to deliver good patient experience and outcomes and to enable efficiencies across systems and organisations. Each team should be accountable for their performance by the individual organisation and the system should be overseen locally by the local Health and Wellbeing Boards.

The role of the Public Health England (PHE) is to nurture and support the local led-public health system; maintain an overview of the whole system's progress in implementing the Public Health Outcomes Framework and have a special responsibility for development of the wider public health workforce.

PHE are also in a unique position to take a strategic overview of the impact of service delivery and should be able to challenge and question commissioners. This should not be confused with performance management. We do not want them to turn into the old model of Strategic Health Authorities.

Directors of Public Health (DsPH) are the principal advisers on health to their local authorities, and PHE provide essential specialist support to DsPH and local government more generally. The role of professional public health advice for local public health systems is a shared responsibility between PHE and DsPH and therefore necessitates strong and close working arrangements between the two to maximise benefits for local communities.

PHE supports the regional Association Directors of Public Health (ADPH) and Local Government Association (LGA) networks in providing the necessary data and intelligence for gauging performance against PH Outcomes Framework and other relevant outcomes.

In addition, PHE can support Local Authorities in accessing the evidence of what works, why it works and how it can be applied locally through identification of good practice, its dissemination and evaluation of actions and interventions undertaken locally. PHE also support Local authorities by providing benchmark data on spend across the various categories of public health activities.

Nationally the LGA and ADPH as the representative membership and professional organisations will work with the sector (and others, including Government Departments and the Inspectorates) to identify the risk of poor performance and offer preventative support through sector led improvement.

Healthwatch England operates both on a national and local level and ensures that

the views of the public and people who use health services are taken into account. The organisation does have a statutory remit to collate evidence of service shortfalls and issues nationally and to ensure the regulators, other arm's length bodies, and government departments, respond accordingly.

CQC have a role in regulating services and can give reassurances that essential standards of quality and safety are met.

Ultimately Ministers retain the right and statutory powers to intervene in areas of poor performance however, it is important that the sector should be provided with an opportunity to address any concerns about a particular council before any form of intervention is invoked, however, there may be circumstances where intervention is determined as urgent and necessary.

2. At a local level which organisation/s do you believe should be responsible and accountable for overseeing improvements in sexual and reproductive health services, and why?

Local authorities have been given the mandate to commission sexual and reproductive health services and should therefore be accountable for overseeing improvements. Local accountability and oversight of sexual and reproductive health services at a local level are varied and multi-faceted.

We start from the fundamental premise that councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area. Councils are primarily accountable to local communities (not government or the inspectorates).

Health and Wellbeing Boards

Health and Wellbeing Boards are responsible for overseeing and coordinating local NHS, social care and public health services.

The past 18 months has been a busy and challenging period of operation for all Health and Wellbeing Boards (HWBs) and their local systems. There is an overwhelming sense – articulated in a number of independent reports published in late 2013 – that the transfer of public health has gone well across all 152 areas, and that all Health and Wellbeing Boards have made a strong and enthusiastic start.

The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Each top tier and unitary authority (152) has their own health and wellbeing board. Board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils.

Health and wellbeing boards also ensure stronger democratic legitimacy and involvement, strengthen working relationships between health and social care, and encourage the development of more integrated commissioning of services.

Portfolio Holder responsible for Public Health

Each upper tier council will also have a portfolio holder responsible for public health. The lead member may be a member of the Council's Executive and/or chair of the Health and Wellbeing Board and have political responsibility for the leadership, strategy and effectiveness of local authority public health services including sexual health services commissioned by the authority.

He/she will have a key role in defining the local vision and setting political priorities for public health in the light of the needs of the area and in the context of the broader political context of the Council.

The lead member is responsible for ensuring high standards in delivery of the council's statutory public health functions. He/she will work closely with other local partners to improve outcomes and will regularly review performance in partnership with the Director of Public Health.

Chief Executive

As Head of the Council's paid service the Chief Executive works closely with local politicians to provide strong and visible leadership, ensure clarity about organizational objectives and the effective allocation and use of resources to achieve them.

Within the specific context of sector led improvement in public health, individual Directors have the key managerial responsibility for the performance and improvement of public health services in their authority.

Directors of Public Health

Directors of Public Health are the principal advisers on health to their local authorities, and PHE provide essential specialist support to DsPH and local government more generally. The role of professional public health advice for local public health systems is a shared responsibility between PHE and DsPH and therefore necessitates strong and close working arrangements between the two to maximise benefits for local communities.

Directors of Public Health have the key managerial responsibility for the performance and improvement of public health services in their authority.

Overview and Scrutiny Committees

Council scrutiny is another important way to check whether sexual health services commissioned by the local authority are effective. Through scrutiny, councillors in upper tier and unitary councils have powers to hold health and wellbeing boards, clinical commissioning groups, Directors of Public Health and healthcare and social

care providers to account for their decisions and actions – they will be interested to know whether local practice in healthcare and social care settings reflects the best available evidence.

Local Healthwatch

Established as part of the Health and Social Care Act 2012. The aim of Local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch also provide or signpost people to information to help them make choices about health and care services. There is one local healthwatch organisation for each local authority area with social services responsibilities

3. What mechanisms within the NHS and public health architecture should be used to hold commissioners and providers to account for the quality and outcomes of sexual health services? For instance, service specifications, performance data and commissioning plans.

Local government is already one of the most transparent parts of the public sector, publishing information to inform citizens, communities and business about local authority democracy, accountability and finances, services and performance, and activities. Local authorities already publish their data based on statutory requirements and local needs and demands, which are often determined by local intelligence and Freedom of Information requests.

For councils to have faith in the Public Health Outcomes Framework, it is important that it does not seek to replicate the approach of the previous National Indicator Set. The outcomes framework should provide the broad context within which Health and Wellbeing Boards develop local priorities – it should not be used to 'performance manage' sexual health services.

The development of three separate but overlapping outcome frameworks for the NHS, public health and adult social care has not reduced the reporting burden for local organisations and does not necessarily facilitate a coordinated and integrated approach to public health, health treatment social care and children's services at a local level. A single outcomes framework would have represented a real commitment to a shared approach between local and national government, health, social care and public health to shared outcomes.

The outcomes framework must support local variation in setting priorities and trajectories that reflect local need as illustrated in the joint strategic needs assessment (JSNA). We are concerned that the framework could be used to manage local performance and that local priorities will be either undermined or overridden by national imperatives.

Service specifications, robust contract management, performance management use national clinical standards as published by the FRSH, BHIVA and BASHH, financial transparency. To our knowledge all commissioners working in the sexual health field are working to integrate all the clinical standards in to their service specifications and

it would be incorrect to assume that the new system has halted this if anything, the transition to Local Authority has provided an opportunity to review and strengthen service specifications due to their robust contract management and transparent financial approaches.

NHS England is responsible for holding Clinical Commissioning Groups (CCGs) to account. We are not clear who holds NHS England to account for the sexual health services they commission within primary care and specialist sexual health services such as within prisons, HIV treatment and SARC.

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

4. To what extent has progress been made against specific ambitions of the Department of Health's Sexual Health Improvement Framework? What steps need to be made for these ambitions to be realised?

The specific ambition within Department of Health's Sexual Health Improvement Framework to 'promote integration, quality, value for money and innovation in the development of sexual health interventions and services' requires long standing local partner arrangements and governance with clear shared outcome across local government and the NHS.

Significant progress has been made in the reduction of teenage conceptions, but also the improved targeting of specific population groups with appropriate advices and services including testing.

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

Collaborative approaches to commissioning along the sexual health pathway have proved challenging. There are also clear links between termination services commissioned by CCGs and contraceptive services commissioned at local authority level. The commissioning input to the tendering of these services from a CCG perspective has been a new arena for many lead clinicians, as previously part of the overall sexual health commissioning in the PCTs.

It is useful to have the England wide SH and HIV commissioners network as a co-ordinating body for SH best practice and sharing of evidence and latest policy. Both the DH, NHSE and PHE are regular presenters at this network and this is only regular clear link with DH on a regular basis. We have been informed that there is a first year report on progress on the DH framework but there appear to be delays in its publication.

The development of a national framework for HIV, sexual and reproductive health

service commissioning in England, with the Department of Health, Local Government Association, NHS England and Association of Directors of Public Health provides a good example of system collaboration. The useful guide focuses on enabling commissioners to establish seamless, integrated care pathways through a whole system approach and describes how this can work in practice.
https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services

The health intelligence support from PHE has enabled better understanding of sexual health issues and informed priorities for commissioning and delivery. The network arrangements enable regional and national debate on local issues.

Locally and nationally there is a need to develop effective commissioning arrangements along the abortion pathway.

There is an issue as to how we better support people aged 40+ in light of changing family structures and lifestyles, the rise of internet dating and the increasing incidence of sexually transmitted infections in these age group.

5. How would you assess the quality and availability of data on sexual health outcomes? How can the use and availability of data on sexual health outcomes support greater accountability of service delivery?

Generally, councils report that data quality is good and much improved. High quality information is central to measuring sexual ill-health in order to identify outbreaks and target high-risk groups, plan services and monitor and evaluate initiatives designed to improve sexual health.

Public health teams will play an essential role in national surveillance for public health by requiring all contracts with providers to include provision to collect and supply mandatory data to relevant organisations in the required form here are a number of mandatory national data collections for sexual health including: Genitourinary Medicine Clinical Activity.

Dataset (GUMCAD) for STIs, Chlamydia Testing Activity Dataset (CTAD), HIV and AIDS Reporting System (HARS), all of which are managed by Public Health England, and Sexual and Reproductive Health Activity Dataset (for contraception and other sexual health care), which is managed by the NHS Information Centre for Health and Social Care.

Data on sexual health outcomes is clearly essential and go some way to measuring the actual service delivery but they do not give the total picture in a local authority area.

The majority of sexual health services have IT systems and software, which facilitate extraction and communication of the necessary outcome and activity data both locally and nationally. However, these systems are less well developed for contraception and clinics should be supported to develop them. When drawing up contracts, local authorities will consider the data they will need for their own use and

for national mandatory reporting.

Availability of local data (small geographical unit) from providers is very variable as no single system/model used locally. Work needs to be done nationally on clarifying legal and governance arrangements to ensure a historical and integrated patient record remains available beyond procurements processes (to maintain patient care, for intelligent commissioning and surveillance).

The delay in certain data, e.g. on teenage conceptions is difficult to avoid. Providers of services, particularly from within the NHS have to recognise the need for regular data returns to enable effective service development. This area needs improvement.

It would be better if some of the data such as HIV was published every six months rather than annually.

Having a dedicated sexual health epidemiologist at PHE regional level is extremely useful as bespoke reports can be created & support for understanding what the data tells us at a local level is greatly valued.

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

6. How would you assess the current accountability arrangements for ensuring there are sufficient numbers of trained healthcare professionals working in sexual health services? If appropriate, what improvements do you believe could be made to strengthen these arrangements?

Data returns on the number of levels of training of staff in SH services should be part of service specifications and communicated to commissioners to enable them to develop services fit for local populations.

GPs are a key provider of sexual health services; in particular, the provision of contraception, and it should be a requirement for GPs to ensure that the appropriate competencies are met. Furthermore, with appropriate training, GP staff can also play an important role in Hepatitis B and HIV testing and identify those who are positive.

There appears to be little national direction on the development of the sexual health workforce, or links made with commissioners in local authorities at local level on this agenda.

In terms of developing the sexual health workforce Health Education England could have an enhanced role. The publication of a national guidance on the appropriate skill mix and staffing levels would be welcome to support this. This could also support LETB engagement with public health locally, with is currently variable across the country.

7. What function should the public health system play in ensuring that education plays a role in promoting good sexual and reproductive health?

Public Health in local government enables the embedding of locally appropriate health promotion messages in school curricula. There is a role for outreach into schools by specific young people's sexual health services and through school nursing teams. Public Health can contribute further by adding more fundamental messages on the nature of good relationships, enabling health choices and resolution of conflicts without the use of violence.

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

There are vital links to be made across, with education particularly, in the relationships and sex agenda (SRE) part of PHSE in schools – this area is key. The Association of Directors of Public Health support the mandation of SRE in all schools. At the local level, schools and colleges should be encouraged to deliver SRE in line with national guidance. By continuing to advocate for SRE to be mandatory, sex and relationships education can equip young people with the knowledge and understanding of relationships, sex and sexual health; whilst supporting them to develop the confidence and skills to negotiate consensual and safe sexual relationships. There are also broader links to be made on developing agendas such as; use of social media, behaviour change approaches, emotional resilience and social norms programmes in schools.

As the public health system in local government matures, we will need to be robust in areas where there may be controversy but we know what works. So for example for children and young people we know what leads to better sexual health. High aspirations, good sex and relationships education, confidential services and better links to areas like alcohol. If local commissioners want to do something different they need to be challenged to explain why their approach will be better for young people. Maintaining and adding to the evidence base is also important as well as the reporting of national datasets to aid local decision making, commissioning and service provision.

The Government's 'Framework for Sexual Health Improvement in England' (March 2013) stresses that young people must have rapid access to confidential, integrated sexual health services at a time and setting convenient to them. NICE guidance published in March 2014 also underlines the need for under-25s to be able to access emergency contraception more easily and for free contraception to be readily available for both men and women in colleges, schools and youth clubs.

Health and Wellbeing Boards will deliver a joined-up approach to public health,

ensuring sexual health issues are considered alongside decisions made on education and transport, for instance. It is vital that colleges and universities work with local sexual health providers and local authorities to ensure young people have access to accurate, high quality and timely sexual health and relationship information that promotes healthy choices, personal resilience and self-esteem.

8. To what extent do women and men have choice and access to the full range of sexual and reproductive health services? How can choice in access to sexual and reproductive health services be improved?

Knowing the needs of your local population through needs assessments, public and provider engagement and consultation are essential.

Choice in access is something that is being addressed via the tendering processes being undertaken by local authorities to address those traditional services commissioned within the NHS are redesigned to ensure they are following best practice and the gold standard “integrated service”.

There does need to be a focus on the way that the services are delivered for the clients, rather than to suit the staff in traditional models for example, by improving opening hours and late evening/weekend access etc.

More can be done in schools and colleges to offer and provide education and normalize access for young people to condoms and contraceptive choices in these settings.

More needs to be done to normalize HIV and STI testing in community settings and GPs in high incidence areas. National campaigns should be used to support initiatives. Testing should be part of the core GP contracts for new registrations with an opt-out policy for blood tests etc. Also testing could be part of an annual health check where cost effective.

Outreach work needs prioritized funding for asylum seekers, sex workers, those with substance misuse and other marginalised groups to ensure access.

There is clearly a need to ensure that men who have sex with men (MSM) are fully addressed in service provision and outreach particularly in light of the recently published data and the increase in STIs etc. in this group.

Also, access by young men aged 15 to 24 years to the programmes on chlamydia screening, as they are not traditionally in such regular contact with health services in the same way as young women.

We should explore the ability of new technologies to increase choice and access to services e.g. GPS apps to locate nearest outlet for EHC, self-sampling for HIV testing.

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