



Government Response to the Health and Social Care Committee report on Sexual Health

Presented to Parliament by the Secretary of State for Health and Social Care by Command of Her Majesty

October 2019

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Government Response to the House of Commons Health and Social Care Committee report on Sexual health (Fourteenth Report of Session 2017–19)

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Introduction

This paper sets out the Government's response to the conclusions and recommendations made in the House of Commons Health and Social Care Committee report on Sexual health (Fourteenth Report of Session 2017–19)¹.

We really welcome the Committee's comprehensive report and have carefully considered all the recommendations that have been made.

Overview

Good sexual and reproductive health is an important contributor to our overall wellbeing. It is an area of public health that impacts on all of us. The Framework for Sexual Health Improvement in England (2013)² set out the Government's ambitions to enable people to stay healthy, know how to protect their sexual health and know how to access appropriate services and interventions when they need them.

Aspects of the nation's sexual health have improved in recent years; more people are accessing services; teenage pregnancies have fallen to an all-time low and the UK became one of the first countries to achieve the United Nations 90 90 90 ambitions on HIV.

However, we recognise that clear challenges remain many of which are identified in the Committee's report.

¹ <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>

² The Framework for Sexual Health Improvement in England 2013, <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

Conclusions and recommendations

Overview – a new national strategy

1: We recommend that Public Health England, in collaboration with a broad-based working group of representatives drawn from all sectors involved in commissioning and providing sexual health services, should develop a new sexual health strategy, to provide clear national leadership in this area. The rest of this report—covering funding, commissioning, services, prevention, and the sexual health workforce—sets out the key areas that this strategy should focus on. (Paragraph 15)

Recommendation 1: We agree with the recommendation and the development of an updated sexual and reproductive health strategy will be led by the Department for Health and Social Care (DHSC) working in partnership with Public Health England (PHE), NHS England and Improvement (NHS E&I), local government and other partners. In the Green Paper Consultation ‘Advancing Our Health - Prevention in the 2020s’ we sought views on the top three things stakeholders would like to see covered in a future sexual and reproductive health strategy.

Our priority for an updated strategy is to work with all partners to achieve our ambition that sexual and reproductive health services are more holistic and that system mechanisms support co-commissioning and joined up patient pathways. We need to use data and metrics to assess unmet need, existing demand for services and how this is managed, taking into account the perspective of the patient, commissioners (both NHS and local government) and the range of service providers.

In the meantime, the aims and objectives of “A Framework for Sexual Health Improvement in England” remain valid and are supported by existing programmes of work at both national and local level.

In addition, we are already delivering new commitments on sexual and reproductive health and HIV which include:

- A commitment by the Secretary of State for Health to end new HIV transmissions in England by 2030.
- Development of a Reproductive Health Action Plan co-ordinated by PHE that will be published this year.
- Delivery of the Pre-Exposure Prophylaxis (PrEP) Impact Trial by NHS E&I, PHE and trial investigators and development of an approach to future commissioning of PrEP nationwide

This work will contribute to the development of the new sexual and reproductive health strategy. We also plan to hold stakeholder roundtables in Autumn 2019 to gather evidence and ideas on priorities. The results of this engagement will be available in early 2020, and together with responses to the Green Paper, will support the production of a new strategy later in that year.

- 2: Sexual health must be sufficiently funded to deliver high quality sexual health services. Cuts to spending on sexual health, as with other areas of public health expenditure, are a false economy. Looking forward to the Spending Review, the Government must ensure sexual health funding is increased to levels which do not jeopardise people's sexual health. Inadequate prevention and early intervention increase overall costs to the NHS. (Paragraph 52)**
- 3: As part of work to develop a new sexual health strategy, we recommend that the national sexual health working group should set out the minimum levels of spending that will be required to ensure that all local areas are able to deliver high quality services (Paragraph 53)**

Recommendation 2: In the last Spending Review, difficult decisions had to be taken across Government to reduce the deficit and ensure the sustainability of our public services. While councils have had to make savings, they have also shown that good results can be achieved at the same time and have found innovative ways to achieve better value. Improved co-commissioning between the NHS, local authorities and other bodies has made better use of limited resources across the system, although more can be done in this area which is detailed in the response to recommendation 4.

In September the Chancellor announced the Spending Round outcome for the next financial year. It was a strong overall settlement for local government including an increase in the level of funding for the public health grant. Local authorities themselves remain responsible for deciding their local health priorities and allocating their resources accordingly.

Recommendation 3: Commissioners must have the flexibility to plan spending against agreed quality outcomes based on the needs of their local population. Some safeguards are already in place and local authorities have a legal requirement to ensure the provision of open-access sexual health services, as set out in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Minimum spend levels in sexual and reproductive health would also risk unintended adverse consequences for other local authority commissioned services.

To help manage the overall increase in demand and provide high quality modern services, local authorities have been utilising technology to manage lower risk and asymptomatic patients. Free, confidential online services which are convenient for patients are increasingly being commissioned. As these services develop, they also have the potential to reach groups not currently engaged with clinic services.

- 4: A wholesale reorganisation of commissioning responsibilities - moving responsibility for sexual health back to the NHS - is not the answer to the problems with commissioning which our witnesses have identified. As our predecessors concluded in their report on Public health post-2013, there is a need to address system boundary issues in the best interests of patients. Strengthened collaboration is key, and longer contracts should be introduced to enable better strategic planning and to lessen the burden that tendering currently imposes. (Paragraph 56)**

Recommendation 4: The NHS Long Term Plan (paragraph 2.4) contained a commitment to review the commissioning arrangements for sexual and reproductive health, health visiting and school nursing services. This review, conducted by DHSC, has now concluded. The Secretary of State announced the outcome of the review at the Royal Society of Medicine 2019 Jephcott Lecture, and the outcome of the review is detailed in the recently published Green Paper ‘Advancing our health: prevention in the 2020s’.

The Green Paper confirms that local authorities will continue to be responsible for commissioning these services, but that the NHS and local authorities must work much more closely together on these services to deliver joined-up care for patients and to embed prevention into the full range of health and other public services. The Green Paper sets out the intention for collaborative commissioning to become the norm for sexual and reproductive health, building on best practice seen across the country. The Green Paper invites views on what more the Government can do to help local authorities and NHS bodies work well together.

Strengthening collaboration will require commitment and action from local authorities and the NHS at both the national and local level. DHSC, NHS E&I, clinical commissioning groups, local government and others will implement joint agreed changes needed to support proposals for co-commissioning and stronger joint working between local government and the NHS. These proposals build on the actions set out in the commissioning survey action plan^[1].

We know that this coordination is vital to continue to improve the sexual health of the population, particularly those who may be at higher risk of poor outcomes. One example of increased collaboration is Local Maternity Systems (LMS). LMS have been established across England, bringing together service users, NHS providers and commissioners, local authorities and other stakeholders across STP footprints to plan and deliver improvements to maternity services. They offer an opportunity to join up NHS and Local Authority services related to maternity around the needs of women and their families. Although, given their remit focused on maternity, they are not the solution for the full range of sexual and reproductive health services, but they may provide an exemplar model for local collaboration and shared planning on sexual health pathways, and make a positive contribution where there is an overlap with maternity services. Some LMS have been successful in this and have been able to influence and support improved sexual health and reproductive services, including:

- West Yorkshire & Harrogate LMS have established a Reproductive Health Expert Group, which reports to the LMS’s Prevention Steering Group. The Expert group will develop recommendations and identify key priorities for reproductive health across the LMS, including what good looks like at “place” and what can be implemented at scale across the LMS. The group has multi-agency membership, led by Public Health with representation from all partners. Recommendations will be coproduced with women and families.
- In the North East, Northumberland, Tyne and Wear and Durham LMS have tried to address the link between sexual health, alcohol misuse and unplanned pregnancies. It was agreed that an alcohol use screening tool would be used when patients present to

^[1] Findings and action plan from a national survey of commissioning arrangements for sexual health, reproductive health and HIV, 2017. <https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review>

sexual health clinics to advise and sign post to support if identified at risk and/or promote a safe drinking culture.

- 5: The national sexual health strategy, supported by a senior working group, must bring new impetus to work to drive forward change and improve services for patients. (Paragraph 57)**
- 6: Recognising the complexity of the provider and commissioner landscape in sexual health, the national sexual health working group should consist of senior representation from all relevant groups, including PHE, NHS England, local government, patient representatives, CCGs, and different provider groups. (Paragraph 58)**
- 7: Building on the recommendations set out by the ADPH and PHE 2017 review, the strategy should aim both to identify and to disseminate best practice, and to work supportively but robustly with areas which need to improve. (Paragraph 59)**

Recommendations 5 and 6: We agree that a Strategy Oversight Group should be established, ensuring this does not create unnecessary bureaucracy, and including all relevant national organisations and partners to oversee development of the new sexual and reproductive health strategy when work gets underway in 2020.

PHE, with DHSC and NHS England and NHS E&I, already co-ordinates an external advisory group for Sexual Health, Reproductive Health and HIV that meets three times a year and includes representation from all of the organisations listed in recommendation 6 and more. The Membership and Terms of Reference is listed in Annex I.

Recommendation 7: The Local Government Association (LGA) and Association of Directors of Public Health (ADPH) already support local areas in undertaking a sector led improvement approach, and the NHS has a range of quality improvement mechanisms to improve sexual and reproductive health provision locally.

PHE has a specific role in providing scientific expertise and a wide range of data to support local areas in understanding their local needs and benchmarking local provision and in providing specialist laboratory service and co-ordinating the response to outbreaks of communicable disease. A PHE guide - Sexual and reproductive health in England: local and national data – has been published and is updated regularly³.

³ Guidance to help health professionals understand the sexual health data available across England and how to access it, 2015. <https://www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data>

- 8: The strategy should set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health. The standards should provide a holistic and unified overview of what good looks like, including setting out how all services should work together, and setting out standards for effective commissioner behaviour. Further recommendations for what these quality standards should include are set out in subsequent chapters. (Paragraph 60)**
- 9: The national sexual health strategy should also set out a clear framework through which local areas will be assessed against the quality standards, with the findings made public both to ensure best practice is widely shared, and to increase public accountability. (Paragraph 61)**
- 10: There is no doubt that care is being delivered by committed professionals, and service users told us the quality of care they received was good. However, access to sexual health services is worsening and is a particular problem for vulnerable groups. To address this, national quality standards should be developed, setting out in detail a consistent basis for best practice across the country. These standards should be developed by the national sexual health working group in consultation with service providers and patients. As a minimum they must cover access, and the provision of services which meet the needs of vulnerable populations. (Paragraph 79)**

Recommendations 8 and 10: The National Institute for Care Excellence (NICE) has already developed a set of Quality Statements⁴ on sexual health published in February 2019. These statements are:

- Statement 1 – people are asked about their sexual history at key points of contact.
- Statement 2 – People identified as being at risk of sexually transmitted infections have a discussion about prevention and testing.
- Statement 3 - Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.
- Statement 4 – People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within two working days.
- Statement 5 – Men who have sex with men have repeat testing every three months if they are at increased risk of sexually transmitted infections.
- Statement 6 – People diagnosed with a sexually transmitted infection are supported to notify their partners.

There is also a NICE Quality Standard on Contraception⁵.

NICE quality standards represents best practice. They are not mandatory; however, organisations and local authorities are expected to take them into account.

⁴ Sexual health quality standard QS178, NICE 2019. <https://www.nice.org.uk/guidance/qs178>

⁵ Contraception quality standard QS129, NICE 2016. <https://www.nice.org.uk/guidance/qs129>

In addition, the model national service specification⁶ published by DHSC and PHE brings together standards set by a range of professional bodies into one specification for use by local authorities. The specification sets out that:

- services should be non-judgmental, confidential and open access,
- the majority of sexual health and contraceptive needs should be met at one site, often by one health professional,
- services should have extended opening hours (evenings after 6pm and weekends) and,
- locations which are accessible by public transport.
- providers of integrated sexual health services are expected to operate in line with most recent guidance and established clinical practice.

This specification was updated in 2018 and DHSC and PHE have committed to updating this on an annual basis.

PHE and the Association of Directors of Public Health will shortly be publishing 'What good looks like' for sexual health, reproductive health and human immunodeficiency virus (HIV). What good looks like is a programme of work that aims to facilitate the collective identification and agreement, by the public health community, on what good quality public health function/programme looks like in any defined place, based on a synthesis of available evidence, examples of best practice, experience and consensus opinions.

PHE have developed Sexual and Reproductive Health Profiles to support local authorities, public health leads and other interested parties in undertaking a local Joint Strategic Needs Assessment, the development of local Health and Wellbeing Strategies and monitoring the sexual and reproductive health of their population. Interactive maps, charts and tables provide a snapshot and trends across a range of topics including teenage pregnancy, abortions, contraception, HIV, sexually transmitted infections and sexual offences. Wider influences on sexual health such as alcohol use, and other topics particularly relating to teenage conceptions such as education and deprivation level, are also included.

In response to the committee's point about access for vulnerable groups, we will need to ensure the needs of all vulnerable groups, such as people with a learning disability, autism or both, and people with severe mental illness (SMI), are considered and included in the development of the new sexual and reproductive health strategy when work gets underway in 2020.

NHS England has already published commissioning guidance to support CCGs in putting in place services that deliver comprehensive physical health assessments, including an assessment of sexual health, and follow up care to people with SMI⁷. The NHS Long Term Plan outlines that by 2023/24 a total of 390,000 people with SMI will receive a physical health check.

⁶ Integrated Sexual Health Services: A suggested national service specification, DHSC 2018.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731140/integrated-sexual-health-services-specification.pdf

⁷ Improving physical healthcare for people living with severe mental illness in primary care: commissioning guidance <https://www.england.nhs.uk/publication/improving-physical-healthcare-for-people-living-with-severe-mental-illness-smi-in-primary-care-guidance-for-ccgs/>

Recommendation 9: As set out in our response to recommendation 7, The LGA and ADPH already support local areas in undertaking a sector led improvement approach, and the NHS has a range of quality improvement mechanisms to improve sexual and reproductive health provision locally. Public benchmarking is seldom an effective way to ensure sharing of best practise.

11: Funding is not currently provided for testing for mycoplasma genitalium (MG) and trichomoniasis vaginitis (TV) STIs. Although some sexual health services are testing for MG and TV without funding, the majority of sexual health services are not, given the increased costs associated with doing so. This is a significant concern. We are equally concerned by the fact that full testing for gonorrhoea is not available in all STI clinics, potentially fuelling the rise in multi-drug resistant, untreatable strains of this serious illness. All STI clinics should be funded to provide a full range of STI testing, including MG, TV and gonorrhoea, and this should be clearly set out in the national quality standards. (Paragraph 85)

Recommendation 11: The Government provides funding to local authorities for public health services, including sexual health services, through the public health grant. It is for local authorities to determine how the public health grant is allocated in their local areas to meet their needs. Sexual health service providers should ensure commissioned services are in line with current national guidance, standards of training and care and quality indicators.

The model national service specification⁸ published by DHSC references guidelines developed by professional bodies including the British Association for Sexual Health and HIV (BASHH). The BASHH guidelines recommend testing for *M. genitalium* and *T. vaginalis* where clinically indicated, and that all individuals with gonorrhoea diagnosed by nucleic acid amplification testing (NAAT) should have cultures taken for susceptibility testing prior to treatment.

Most specialist sexual health services (over 90%) report TV diagnoses to PHE. There are several methods available for the diagnosis of TV and we understand that not all of these are available at every specialist sexual health service and some are more likely to correctly identify individuals with TV than others (i.e. tests have variable sensitivity). Most specialist sexual health services have access to microscopy for the diagnosis of TV but fewer have access to NAATs (higher sensitivity than microscopy). Testing for *Mycoplasma genitalium* is not yet universally provided by sexual health services.

Gonorrhoea is routinely tested for in specialist sexual health services that provide STI treatment and care. The diagnosis of gonorrhoea is established by the detection of N. gonorrhoeae at an infected site, either by nucleic acid amplification tests (NAATs) or by culture. BASHH guidelines highlight that the approach and method used to test for gonorrhoea will be influenced by the clinical setting, storage and transport system to the laboratory, local prevalence of infection and the range of tests available in the laboratory. No test for gonorrhoea offers 100% sensitivity and specificity. PHE actively monitors, and acts on, the spread of antibiotic resistance in gonorrhoea and potential treatment failures. In response to the more recent cases of extensively drug resistant gonorrhoea, PHE has

⁸ Public health services non-mandatory contract. <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published>

introduced enhanced surveillance at sexual health services to identify and manage ceftriaxone resistant strains promptly.

12: Cervical screening is a life-saving intervention for a cancer which is largely preventable, yet still claims two lives a day. However, cervical screening rates have fallen to a 20-year low. We were shocked to hear how fragmented commissioning arrangements mean that in some parts of the country, women are not able to have cervical screening done at the same time as other sexual health provision. (Paragraph 89)

13: Cervical screening must be clearly included as part of national quality standards for sexual health. But there is a need for more urgent action on this issue to save lives and prevent women having to undergo a second examination for a test that could and should be completed at a single visit. We call on PHE and NHS England to set out what immediate actions they are taking to address this in their response to this report. (Paragraph 90)

Recommendations 12 and 13: Cervical screening sample taking is carried out in different settings but predominantly within primary care (GP practices) as part of the national NHS E&I Section 7A agreement cervical screening programme. In addition to the national programme for inviting women aged between 25 and 64 years to specific screening appointments, there has been an additional route for opportunistic cervical screening through it being offered to women who attend a sexual health clinic, funded by local authorities. It is acknowledged that arrangements for cervical screening in sexual health clinics are variable across the country according to local requirements. Local authorities are responsible for commissioning sexual health services and, since 2013, some have continued to include and fund opportunistic cervical screening within their sexual health service contracts. In other areas NHS E&I regional public health commissioning teams have commissioned and funded opportunistic cervical screening from sexual health services.

To address the variations in service provision and the inequalities in uptake, NHS E&I is working with DHSC and PHE to amend the national Section 7a cervical screening agreement to enable extension of the delivery model within sexual health clinic settings. This will support regional NHS E&I public health commissioning teams to routinely contract opportunistic cervical screening from Integrated Sexual Health service providers. The aim is to include delivery of this intention within the Section 7A public health commissioning agreement from 2020/21.

14: Long Acting Reversible Contraception (LARC) is the most effective way of preventing unplanned pregnancy, and its more widespread availability has been credited with reducing teenage pregnancy rates. However, we are very concerned to hear that because of changed commissioning and funding arrangements, many women are no longer able to access some forms of this method of contraception, leading to a 13% drop in its use. Action must be taken to reverse this worrying trend. Access to LARC at all locations where sexual and reproductive health services are provided— including primary care—must form a key part of the national quality standards. (Paragraph 95)

Recommendation 14: We recognise that we are seeing a mixed picture on access to LARC access currently:

- Within sexual and reproductive health services prescriptions of LARC methods increased by 25% between 2012/13 and 16/17 from 272,000 to 342,000.
- But in primary care, prescriptions of LARC decreased from 1.3million to 1.2million.

This is concerning given contraception is crucial to plan, delay and space pregnancies and improved birth outcomes and healthy maternal behaviours during pregnancy. Contraception also reduces pregnancy-related morbidity and mortality, reduces the risk of developing certain reproductive cancers, and can be used to treat many menstrual related symptoms and disorders.

We also know that contraception is highly cost effective and good access is important to women. PHE undertook a survey and focus groups discussions with 7,500 women about their experiences of reproductive health and making future choices. The most important topic for most women was preventing pregnancy, particularly for those in younger age groups.

The new sexual and reproductive health strategy will consider how best to address the provision of the full range of contraceptive choices for women, building on the upcoming Women's Reproductive Health Action Plan (co-ordinated by PHE in collaboration with NHS E&I, DHSC, LGA and ADPH). The Action Plan will be published later this financial year.

Co-commissioning and seamless pathways between local government and NHS commissioned services are a vital component to ensuring women's reproductive health needs are met.

Linked to this DHSC, NHS E&I and PHE are undertaking work to promote the development of online contraceptive prescribing and digital reproductive e-health. At any one time 78% of women in Britain will require help with contraception or pre-conception counselling and expanding access to online contraceptive prescribing has the potential to reach more women, free up clinical time and allow for more focus on vulnerable women who may require more support through quality face to face appointments. This work also fits with the digital ambitions in the NHS Long Term Plan and NHS Digital Strategy.

In addition, the model Integrated Sexual Health Service Specification includes a key objective to increase uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods including LARC for all age groups. It also recommends that NHSE and CCGs should facilitate access to training for general practitioners (both established and those in training) practice nurses, and other groups for specialist contraceptive services such as LARC.

15: There is huge frustration amongst both patients and clinicians about the current inequitable access to PrEP, a new treatment which can prevent HIV. We note that NHS England has expanded its pilot sites to increase the number of people able to benefit from PrEP, but access remains a postcode lottery. We call on NHS England to review whether it is unreasonably restricting access to PrEP due to disputes about funding pathways rather than questions about its effectiveness. PrEP should also be covered within the national quality standards—if it is deemed to be an effective and cost-effective treatment it should be universally available. (Paragraph 100)

Recommendation 15: Whilst studies such as PROUD demonstrated clinical effectiveness of using PrEP to prevent HIV acquisition in the highest risk groups, there remain outstanding questions about PrEP uptake which affect the assessment of clinical and cost effectiveness and cost impact. This was the conclusion of the NICE review of evidence⁹.

Therefore, a 3-year trial began enrolment to 10,000 places in October 2017. The trial is providing access to NHS England funded PrEP drug via participating sexual health services which are commissioned by local authorities. The trial not only provides access to this important HIV prevention intervention but ensures the collection and analysis of data to help inform planning for services for HIV prevention in the future.

The uncertainty on issues such as likely uptake has already been clearly demonstrated by the trial. NHS E&I is now funding the drug for over 13,000 enrolled individuals, far outstripping original expert predictions of uptake. By mid-November 2018, the trial had recruited to 100% of the initial 10,000 places and NHS E&I had already committed to funding drug and research costs for an additional 3,000 individuals following the recommendation of researchers. In 2019, trial researchers recommended that the trial should be doubled in size to up to 26,000 places so that recruitment could reach a 'steady state' and the trial could inform the design and roll out of future commissioning in partnership with local authorities. NHS E&I committed to fund the drug and research costs associated with the further expansion up to 26,000 participants, where this was supported and approved by the local authority commissioners of the trial sites. Where such approvals have been given, extra places started to become available in March this year.

DHSC, with NHS E&I, PHE and local government are currently undertaking technical work on possible commissioning models for PrEP.

On HIV more generally, NHS E&I continues to make a leading contribution to HIV treatment and prevention efforts. In 2017 in the UK, 85,537 people with diagnosed HIV were being cared for in NHS HIV services. Almost all of those people with HIV were receiving effective treatment (98%), such that their virus was fully suppressed (97%). This achievement more than exceeds the UNAIDS 90 90 90 target to help end the HIV/AIDS epidemic. Over the last 4 years, NHS E&I fast-tracked the commissioning of 'treatment as prevention' for people with HIV to protect their sexual partners and approved immediate access to treatment for all people diagnosed with HIV.

⁹ Pre-exposure prophylaxis of HIV in adults at high risk: Truvada, NICE 2016.
<https://www.nice.org.uk/advice/esnm78/chapter/Key-points-from-the-evidence>

Prevention

16: We welcome the Minister's indication that prevention in sexual health will be a central part of the prevention Green Paper, and we expect the Government to set out in the response to this report how that commitment will be followed through into action, including the funding required to put it into practice. (Paragraph 108)

17: Prevention—activities that encourage healthy behaviours and changes that reduce the risk of poor sexual health outcomes—must be prioritised and adequately funded. Prevention is or should be an integral part of all sexual health provision, and the new national quality standards should therefore include preventative interventions within all aspects of sexual health. (Paragraph 117)

Recommendation 16: As set out in our response to recommendations 1 and 4, the Green Paper “Advancing Our Health: Prevention in the 2020s” sought views of how we can encourage and support collaborative commissioning of sexual and reproductive health services between local government and the NHS and on the priorities for developing a new sexual and reproductive health strategy.

Recommendation 17: We agree that sexual health promotion and prevention work is vital to help people to make informed and responsible choices, with an emphasis on making healthy decisions. Effective health promotion addresses the prejudice, stigma and discrimination that can be linked to sexual ill health. However, service provision and treatment can also play key roles in prevention, in diagnosing STIs and HIV and preventing their onward transmission and in providing contraception to prevent unwanted pregnancies. Local authorities are responsible for HIV prevention and sexual health promotion work at local level. PHE funds prevention programmes at national level.

HIV Prevention England is the national, PHE-funded HIV prevention programme for England currently delivered by Terrence Higgins Trust. It delivers a nationally co-ordinated programme of HIV prevention work with United Kingdom (UK)-based black African people and with gay, bisexual and other men who have sex with men (MSM). It brings together campaigns, online services, local work, sector development and policy work. It works closely with black African, gay, and faith communities, NHS clinics and local authorities. It takes a combination HIV prevention approach and includes interventions associated with HIV testing, HIV treatment and undetectable = untransmissible (U=U), PrEP and condoms.

The National Health Promotion Programme for Sexual Health and Reproductive Health Information (Sexwise) provides clear, impartial, up to date information for the public and healthcare professionals. This programme fulfils two main functions in order to provide a comprehensive sexual health and reproductive health information to:

1. Healthcare professionals - to increase awareness and to assist in clinical and non-clinical consultations with patients
2. The public - to raise their awareness and knowledge of sexual and reproductive health to enable them to make well informed choices, influence behaviour change and take control of their own sexual health.

Our response on national quality standards is set out in recommendations 8 and 10.

18: The Government must take a strong line on participation in Relationships and Sex Education (RSE). Public health arguments are overwhelmingly in favour of ensuring that all children have appropriate RSE. (Paragraph 119)

19: Furthermore, relationships and sex education should be

- **high quality—in particular, age-appropriate, culturally competent, strong on diversity and inclusion, and up-to-date with medical advances;**
- **delivered by appropriately qualified people; and**
- **linked appropriately and usefully to local health priorities and local services.**

In its response to this report, the Government should indicate what steps it is taking to ensure that each of these recommendations is being implemented. (Paragraph 120)

Recommendations 18 and 19: The Government wants all young people to be happy, healthy and safe. We want to equip them for adult life and give them the knowledge they need to make a positive contribution to society. That is why we are making Relationships Education compulsory for all primary aged pupils, Relationships and Sex Education (RSE) compulsory for all secondary aged pupils from September 2020. From that point, Health Education will also be compulsory for all pupils in state funded schools, to address the importance of physical health and mental wellbeing. If a school feels like they are ready to do so, they may start teaching these new subjects from September 2019. These subjects have been shaped by a thorough engagement process including a Call for Evidence and public Consultation.

This Government believes it is crucial that all young people can understand what healthy relationships look like and how to stay safe.

The draft statutory guidance for relationships education, relationships and sex education (RSE) and health education was developed following our call for evidence which received over 23,000 responses from parents, young people and schools and included engagement with 90 organisations (including faith groups) to discuss the content that should be covered in this area of the curriculum. Following the call for evidence, we held a public consultation on the draft guidance that received responses from over 40,000 individuals and organisations. We have now published the government response to the consultation¹⁰ and the new statutory guidance was published in June¹¹. We agree that teaching must be evidence based and this is set out in the draft guidance. The guidance is also clear that teaching should be factual, focus on the law in these matters, be age appropriate, and ensure that all students have information about their local sexual and reproductive health services.

This Government is committed to ensuring schools are supported and ready to teach these new subjects to a high standard. Available international evidence states that trained educators are essential for the delivery of high quality RSE. In February, we announced that in the 2019-20 financial year, a budget of £6 million would be made available to develop a programme of support for schools. Further funding beyond this will be subject to the

¹⁰ <https://www.gov.uk/government/consultations/relationships-and-sex-education-and-health-education>

¹¹ <https://www.gov.uk/government/publications/changes-to-personal-social-health-and-economic-pshe-and-relationships-and-sex-education-rse>

forthcoming Spending Review. Funding will be used to develop a central programme of support for schools focusing on tools that will improve schools' practice, such as an implementation guide to support the delivery of the content set out in the guidance and targeted support on materials and training.

Workforce

20: It is clear that fragmented arrangements for the commissioning and provision of services have meant that workforce planning, development and training have suffered. The Harding review should set out a deliverable plan for the workforce needed to deliver sexual health services across England in the next 10 years. Meanwhile, the national sexual health strategy should include a clear programme of further action to re-establish training and development for both the current and future sexual health workforce at the heart of commissioning and provision arrangements. (Paragraph 133)

Recommendation 20: In September 2018 HEE published its report 'Improving the delivery of sexual health services.' In the report HEE made a number of recommendations to work with system partners to support the workforce.

Since the scoping work was completed HEE has funded and worked with the Royal College of Nursing to develop a training directory highlighting training and qualification requirements for registered nurses, midwives, health advisers and nursing associates as well as unregistered healthcare support staff working in sexual health. This was published with an accompanying publication: Sexual and Reproductive Health – Education, Training and Career Progression in Nursing and Midwifery¹². HEE are also developing an integrated advanced clinical practitioner framework for Sexual Health and HIV which is to be evaluated during 2019. We agree that workforce issues should also be considered as part of the development of the new sexual and reproductive health strategy and the Department will work with appropriate organisations to produce the strategy, including the Nursing and Midwifery Council.

In January 2019, the Secretary of State commissioned Baroness Harding, working closely with Sir David Behan, to lead development of a comprehensive workforce implementation plan (also referred to as the NHS People Plan). The Plan was to provide a strategic point of focus for existing and future policy around workforce supply and set out a plan to deliver the workforce required to support the NHS Long Term Plan. The interim plan¹³ was published in June this year and was discussed at the Commons Select Committee.

The interim Plan has three main themes: making the NHS the best place to work, improving the leadership culture, addressing urgent workforce shortages in nursing, delivering 21st century care, a new operating model for workforce.

At national level, there will continue to be a single, joined up approach to people planning. This will be supported by greater alignment of the mandates and plans for Health Education England and NHS E&I, with the new Chief People Officer and a new National People Board overseeing the shared strategy.

Regionally, there will be much closer working and alignment across HEE and NHS E&I,

¹²

¹³ Interim NHS People Plan, 2019. <https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/>

enabling a more comprehensive view of workforce requirements and priorities across each region and how these complement service and financial plans.

Locally, Integrated Care Systems (ICSs) will take on greater responsibility in the long term for workforce and people related activities, with the appropriate resources and when ready to do so. Over time, and within a national framework, they will lead on developing and overseeing population-based workforce planning for local health services.

There is now a lot of work to do to make sure the final NHS People Plan tells a credible story about workforce to deliver the NHS Long Term Plan and to make an effective case for further investment in workforce, whether from new Spending Review resources or from spending commitments from the NHS ringfence. A final People Plan will be published soon after the conclusion of the 2019 Spending Review.

Terms of Reference – External Advisory Group (EAG) for Sexual Health, Reproductive Health and HIV (SH, RH & HIV)

Purpose

The EAG will provide PHE with external independent advice, expertise and challenge on its strategic direction, approach, and products within the topic area of Sexual Health, Reproductive Health and HIV (SH, RH & HIV).

The Group will be jointly chaired by external members. The inaugural co-chairs are Professor Jane Anderson (Homerton University Hospital) and Dr Connie Smith. This group will report to the PHE Corporate Programme Board (CPB).

Roles and Responsibilities

1. Provide external input and challenge to PHE strategic business plans for SH, RH & HIV
2. Provide advice and support to enhance PHE's support for local and national delivery (local authorities, NHS England, CCGs) of SH, RH & HIV related work
3. Identify opportunities to provide PHE system leadership for SH, RH & HIV.

Membership and Structure

The EAG will include direct service providers, professional associations, commissioners, policy makers and key stakeholders. Alongside our external stakeholders will be representative PHE internal senior team leaders in the topic area of SH, RH & HIV from the PHE Corporate Programme Board (CPB).

Membership will include:

| | | | |
|---|-----------|-------------------------|--|
| 1 | Co-chair | Professor Jane Anderson | Homerton Hospital |
| 2 | Co-chair | Dr Connie Smith | |
| 3 | PHE | Professor Aliko Ahmed | Midlands & East of England PHE Centre Director, Co-chair of Corporate Programme Board |
| 4 | PHE | Professor John Newton | Director of Health Improvement, Senior Responsible Officer and Co-chair of Corporate Programme Board |
| 5 | PHE & DPH | Prof Kevin Fenton | PHE Senior Strategic Advisor on SHRH&HIV and Strategic Director, Place and Wellbeing |

| | | | |
|----|--|--|---|
| | | | Director of Public Health, Southwark Council |
| 6 | PHE | Mr Adam Winter | PHE National Lead, SH RH&HIV (Health Improvement) |
| 7 | Microbiology Society | Dr Mike Beeton | Specialist laboratory and diagnostic expertise |
| 8 | Department of Health and Social Care | Ms Andrea Duncan | Lead for SHRH&HIV portfolio |
| 9 | Local Government Assoc. | Mr Paul Ogden | Lead for SHRH&HIV portfolio |
| 10 | NHS England (Specialised Commissioning) | Mr Rob Coster | Lead for HIV portfolio within specialised commissioning |
| 11 | NHS England (CCG) | Vacancy (was Tony Johnston) | CCG representative on SHRH&HIV topic |
| 12 | HIV Clinical Reference Group | Dr David Asboe | Chair |
| 13 | Association of Directors Public Health | Professor Jim McManus / Dr S.J Louise Smith | DPH, Hertfordshire County Council / DPH, Norfolk County Council |
| 14 | English Sexual Health Commissioners Group | Mr Rob Carroll | Co-chair, representing ESHCG |
| 15 | Health Education England | Dr Ann Boyle | Lead for SHRH&H training and workforce issues |
| 16 | British HIV Association | Dr Chloe Orkin | Chair |
| 17 | British Association for Sexual Health and HIV | Dr Olwen Williams | President |
| 18 | Faculty of Sexual Reproductive Healthcare (FSRH) | Dr Asha Kasliwal | President |
| 19 | Royal College of Obstetricians and Gynaecologists (RCOG) | Prof. Lesley Regan | RCOG Council member |
| 20 | Royal College of General Practitioners (RCGP) | Dr Anne Connolly | Clinical Lead for HIV, sexual and reproductive health |
| 21 | Terrence Higgins Trust | Mr Ian Green | CE, one of PHE's contracted delivery partners |

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|----|---|------------------------|---|
| 22 | NAZ Project London | Ms Marion Wadibia | CEO, representing issues relevant to BAME communities |
| 23 | LGBT Foundation | Mr Rob Cookson | CEO, representing issues relevant to LGBT communities |
| 24 | Brook | Ms Lou Brack | Head of Nursing |
| 25 | BHA | Dr Priscilla Nkwenti | CEO of the BHA for Equality in Health and Social Care |
| 26 | National AIDS Trust | Ms Deborah Gold | CEO |
| 27 | HIV Third Sector Providers Forum | Matthew Hodson | Executive Director, NAM |
| 28 | Marie Stopes UK | Dr Imogen Stephens | Medical Director |
| 29 | British Pregnancy Advisory Service (BPAS) | Ms Ann Furedi | Chief Executive |
| 30 | NIHR HPRU on Bloodborne & Sexually Transmitted Infections | Prof Caroline Sabin | Director |
| 31 | UCL | Prof Judith Stephenson | Professor of RH and SH RH UCL EGA Institute for Women's Health Faculty of Pop Health Sciences |

PHE Observers

| | | | |
|---|-----|---------------------|--|
| 1 | PHE | Professor Noel Gill | National Infection Service Lead (NIS) |
| 2 | PHE | Gwenda Hughes | Co-chair, Health Protection Subgroup of the CPB |
| 3 | PHE | Clare Perkins | Deputy Director of Programmes and Priorities |
| 4 | PHE | Sue Mann | Reproductive Health Lead |
| 5 | PHE | Alison Hadley | Teenage Pregnancy Advisor |
| 6 | PHE | Claire Sullivan | Co-chair, Health & Wellbeing Subgroup of the CPB |
| 7 | PHE | Kate Folkard | Co-chair, Health & Wellbeing Subgroup of the CPB |
| 8 | PHE | Kirsty Foster | Co-chair, Health Protection Subgroup of the CPB |

| | | | |
|---|-----|--------------|--------------------------|
| 9 | PHE | Helen Duncan | Health Intelligence Lead |
|---|-----|--------------|--------------------------|

Attendance

The Group shall be quorate if at least one co-Chair and 50% of the external members are present. Members may send alternates to meetings, but this should be by exception.

Accountability and Reporting

The External Advisory Group is accountable to and reports to the Corporate Programme Board (CPB).

Overall governance structure and interdependencies with other parts of the organisation

The governance and accountability structure can be found in appendix 1.

Frequency of meetings

The Group shall meet at least tri-annually, unless the Chair determines otherwise.

Papers and agenda items

Standing items, with papers, will include:

- Minutes and matters arising
- Action tracker
- Substantive agenda items (including associated papers)
- For information: Programme documentation, as appropriate.

Papers and proposals for other agenda items for the Group will be submitted through the Co-Chairs at least 6 weeks before the date of the Group meeting. Late and tabled papers will only be accepted with the agreement of the Co-Chairs.

The meeting draft minutes will be approved by the co-Chairs and circulated to the EAG members within one month of the meeting. Corrections will be requested by e-mail to enable the minutes to be signed off as final. Finalised minutes will be circulated and can be shared by members with their constituencies. By exception, there may be specific sections of the minutes that will remain confidential. If this applies, it will be stated explicitly during the meeting.

Review

These Terms of Reference will be reviewed annually by the SH RH and HIV Corporate Programme Board. The CPB will also evaluate the EAG's performance at least annually.

Jane Anderson
EAG Chair

Connie Smith
EAG Chair

Aliko Ahmed
CPB co-Chair

John Newton
CPB co-Chair

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