Dear Secretary of State,

**Sexual and reproductive health sector call to strengthen the public health framework**

The sexual and reproductive health (SRH) sector strongly welcomes the Government’s call for evidence on the impacts of the current prescribing regulations for local authority public health activity. This is a much-needed stock-take of the existing framework following the radical changes resulting from the 2012 Health and Social Care Act which transferred public health responsibilities from the NHS to local authorities.

We represent hundreds of thousands of healthcare professionals who work within the current public health framework as well as service users and the general population whose needs must be considered first and foremost in public health policy.

The implementation of the existing public health framework has brought challenges, and these have undoubtedly been exacerbated by significant cuts to the public health grant. Financial pressures have impacted on local authorities’ ability to even maintain the current levels of service provision, and evidence points out that budget reductions are leading to unacceptable variation in the quality and quantity of services available to the public.

Strengthening the SRH mandate by enhancing the scope of prescribed activity and accountability mechanisms is vital to ensuring that key services are consistently provided across the country. However, much remains to be done to tackle regional inequalities. Cuts, coupled with fragmented commissioning, have had a severe impact on access to contraception, including emergency contraception. They are also undermining the delivery of effective sexually transmitted infection (STI) prevention, testing and treatment services, which is especially concerning considering the recent explosion in syphilis rates and the continued spread of antibiotic-resistant gonorrhoea. The significant pressures caused by the cuts are limiting patient access to SRH services across the country and are ultimately jeopardising health outcomes as a result.

Non-prescribed public health activities have faced significant service cuts too (for example, HIV prevention funding in areas of high prevalence dropped by a third in two years). This strongly suggests that any potential removal of the public health grant ring-fence will inevitably lead to further redistribution of funds to other equally-as-pressured parts of the system. We are also concerned that the proposal to fund public health through locally retained business rates in 2020 could compound health inequalities in socio-economically deprived areas. With increasing uncertainty surrounding local authority financing, it is vital that the public health framework is strengthened to ensure that SRH services are truly open-access and available to all, so that health inequalities are not deepened.
We would therefore like to bring to DHSC’s attention a common set of recommendations agreed on by the SRH sector which are important to strengthen the effectiveness of the SRH mandate:

1. That sexual and reproductive healthcare services are fully-funded based on the needs of the population.

2. SRH services must be delivered by local authorities in accordance with nationally recognised standards in SRH, such as FSRH, BASHH and the new BHIVA standards, guaranteeing high-quality SRH care. These standards should be expressly referred to in the mandate to protect services from being compromised by cuts to budgets and politicisation at local authority level. We would particularly like to see DHSC and PHE collaborate on strengthening the SRH mandate for use at the local authority level.

3. For tools to be developed to support local authorities to assess the impact of their prescribed activities on health inequalities, such as inequality impact assessments.

4. DHSC to ensure that joint working happens in practice, supporting local authorities and Clinical Commissioning Groups with their SRH commissioning responsibilities in line with the collaborative and whole-system approach to commissioning outlined in PHE’s ‘Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV’.

5. Given the APPG for Sexual & Reproductive Health’s Inquiry findings that there is a lack of clarity with regards to accountability in the current system, that existing accountability mechanisms are enhanced, enabling the Secretary of State to hold local authorities to account in their devolved delivery of his public health responsibilities.

6. That PHE has stronger enforcement powers to enable the agency to act on the findings and analyses it produces and to hold local authorities and commissioners to account for their performance.

7. Accountability lines must be further developed if the business rates retention system is introduced in 2020, with further consultation in this regard.

We are clear that changes are needed to make the public health regulations work now, and to ensure that they are fit for the future. We urge the Government to consult further on specific changes and to do so in the context of clear proposals for how public health responsibilities will be funded in the future. It is essential that the sector has further opportunity to scrutinise the framework in this context.

Finally, we strongly encourage the Department to take fully into account the detailed recommendations set forth in our individual responses.

Yours sincerely,

Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists (FSRH)  Family Planning Association (FPA)
National AIDS Trust (NAT)  British Association for Sexual Health and HIV (BASHH)
British HIV Association (BHIVA)  Terrence Higgins Trust (THT)
Brook  Faculty of Public Health (FPH)