## Proposals for the relocation of sexual health services

### 1. Context

Effective action to improve sexual and reproductive health: -

- improves personal and population wellbeing
- saves more than it costs in terms of the overall public purse
- provides opportunities to tackle wider social ills such as domestic violence, child sexual exploitation and drug and alcohol dependency
- is an essential element in comprehensive plans to narrow health inequalities[1].

Local authorities are mandated [2] to provide, or commission open access sexual health services i.e.: -
*services for*

*i) preventing the spread of sexually transmitted infections;*
*ii) for treating, testing and caring for people with such infections; and*
*iii) for notifying sexual partners of people with such infections.*

And —

*i) advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and*
*ii) advice on preventing unintended pregnancy.*

These services are only a part of the overall system. An effective approach to improving sexual health requires multiple commissioners and providers to coordinate their actions to ensure residents benefit from evidence based, seamless pathways of care that work to prevent problems occurring wherever possible and minimise the harm resulting when they do.

**Table 1: Overview of commissioning and provider arrangements relevant to sexual health**

| Service | Commissioner | Provider |
|---|---|---|
| HIV prevention and sexual health promotion | Local authorities | Specialist provider(s) |
| C card (free condom distribution) | Local authorities | Many pharmacists and CYP services |
| Long Acting Reversible Contraception (LARC) | Local authorities | Some GPs |
| Contraception services including LARC | Local authorities | Specialist family planning provider |
| Contraception services (including EHC but excluding LARC) | NHS England /CCGs | All General Practitioners |
| Emergency hormonal contraception (EHC) | Local authorities | Some pharmacists |
| Testing and treatment of STIs including chlamydia screening | Local authorities | Specialist GUM provider |
| Sexual health aspects of psychosexual counselling | Local authorities | Specialist GUM provider |
| Non- sexual health aspects of psychosexual counselling | CCGs | Specialist GUM provider |
| HIV treatment and care | NHS England | Specialist provider |
| Sexual assault referral centres | NHS England | Specialist provider |
| Cervical screening | NHS England | General Practitioners |
| Community gynaecology | CCGs | Specialist provider |
| Vasectomy and sterilisation services | CCGs | Specialist provider |
| Abortion services | CCGs | Specialist provider |

Adapted from Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities, Dept of Health 2013.

## 2. Description of need at borough level

Most if not all of us are likely to have need for advice and / or care from sexual health services at some point in our lives; but some groups notably young people, men who have sex with men, black ethnic groups and disadvantaged communities are at higher risk of poor sexual health and likely to have greater need to care. As a result, the need for sexual health services will vary between boroughs and between communities within boroughs reflecting the size and make-up of their population.

STI rates are highest in urban areas, especially in London, reflecting the distribution of the population groups at greatest risk of infection. Locally, rates of STI and HIV infection are significantly higher in Barking and Dagenham than in Redbridge, Havering and England as a whole. Likewise, rates of teen conception are high in Barking and Dagenham and similar to the national average in Havering and Redbridge. But abortion rates and rates of repeat abortion are high in all 3 boroughs whereas provision of long acting reversible contraception (LARC) – the most effective form – is relatively low.

**Table 2: Indicators of sexual and reproductive health**

| | Barking and Dagenham | Havering | Redbridge | England |
|---|---|---|---|---|
| Rate of new STIs excluding chlamydia diagnoses / 100,000 15-24 year olds | 1099 | 800 | 791 | 829 |
| Chlamydia detection rate per 100,000 young people aged 15-24 years | 2173.7 | 1374.0 | 1319.1 | 2012.0 |
| Rate of HIV cases per 1000 aged 15-59 years | 6.1 | 1.9 | 2.9 | 2.1 |
| % of HIV diagnoses made at a late stage of infection | 48.8% | 41.7% | 49.0% | 42% |
| Rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care | 19.6 | 13.9 | 12.0 | 32.3 |
| Rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women aged 15 to 44 years | 35.7 | 24.2 | 20.3 | 31.5 |
| Total abortion rate per 1,000 females population aged 15-44 years | 31.2 | 22.5 | 24.5 | 16.5 |
| % of those women under 25 years who had an abortion in that year, who had had a previous abortion | 33.0% | 31.5% | 35.5% | 27.0% |
| Under 18 conception rate per 1,000 females aged 15 to 17 years (2013) | 40.1 | 26.2 | 16.9 | 24.3 |

Source: PHE Sexual and Reproductive Health Profiles

The need for services is likely to increase in suburban areas like Havering and Redbridge as a result of continued population flows from inner London.

## 3. Current arrangements for the provision of sexual health services

Responsibility for commissioning sexual health services transferred to local government in April 2013 at which time the London Boroughs of Havering (LBH), Barking and Dagenham (LBBD) and Redbridge (LBR) agreed separate but essentially identical contracts with Barking, Havering and Redbridge University Hospitals Trust (BHRUHT), elapsing September 2015, for the provision of integrated GUM and family planning services.

In summary the contract specifies: -

- That the provider is paid via a simple Payment By Results (PBR) arrangement for both arms of the service.
- And services are provided via two level 3 hubs (Queens Hospital and Barking Hospital) providing a full range of GUM and family planning services and eight spokes providing 'uncomplicated' contraception services – including in most, but not all, the fitting of LARC.

### 3.1 GUM services

Currently there are 34 level three GUM services in London including Queens and Barking Hospitals. Their distribution is more a matter of historical chance than purposeful planning. Currently six boroughs, including Redbridge, do not have a service within their own borders but this is not necessary for Councils' to meet their duty to provide services for people in the area.

NB. This number will increase as Councils across London reconfigure services to complement the London Sexual Health Transformation Programme (see section 4.1).

As services are open access, residents can attend any they wish. Nonetheless in 2014 around 75% of all GUM attendances for Barking and Dagenham (n ≈ 5700) and Havering residents (n ≈ 4900) were at one of the two GUM services operated by BHRUHT, falling to under 40% (n ≈ 3200) for Redbridge residents.

Taking the two sites together, BHRUHT holds GUM clinics 6 days a week, with one evening clinic and one dedicated young person clinic.

### 3.2 Family planning services

Nationally, it's estimated that about 80% of all contraceptive care is provided by GPs.[3] Prescribing data suggest that the situation locally is similar.

The responsibilities of GPs regarding contraceptive care cover the great majority of methods but not the fitting of Long Acting Reversible Contraception (LARC) which is specifically excluded from the relevant GMS Additional Services specification. However some GPs with additional skills are separately commissioned by Councils to provide LARC in the community.

Hence, there is a significant overlap between the contraceptive services offer in general practice and specialist family planning services – ¾ of the interventions provided by BHRUHT could have also been provided by a GP. Hence the specialist family planning services commissioned by the Council can be viewed as a complement to the general practice offer - for women with specialist needs or who are otherwise unable or unwilling to attend their GP rather than a substitute as GPs remain the preferred provider for the majority of women.

As with GUM services, residents can attend specialist family planning services elsewhere but BHRUHT is the largest provider for all 3 boroughs; responsible for 90% of LBH contacts (n≈6900), 85% of LBBD contacts (n≈5800) and 60% of LBR contacts (n≈4000).*

BHRUHT provides family planning services from 10 sites. Barking and Queens Hospitals offer a full level 3 service including uncomplicated contraception and LARC as well as catering for women with complex needs. Clinics at the other 8 sites provide uncomplicated contraception, in most cases including the fitting of LARC devices.

**Table 2: Breakdown of BHRUHT family planning activity by site, 2014-15**

| | LBBD | | LBH | | LBR | | All BHRUHT activity* | |
|---|---|---|---|---|---|---|---|---|
| Barking Hosp | 1065 | 16.5% | 82 | 1.1% | 260 | 4.9% | 1465 | 7.2% |
| Vicarage Fields HC | 967 | 15.0% | 26 | 0.4% | 141 | 2.6% | 1170 | 5.8% |
| Oxlow Lane HC | 2105 | 32.6% | 236 | 3.2% | 94 | 1.8% | 2510 | 12.4% |
| Queens Hosp | 1311 | 20.3% | 2826 | 38.1% | 563 | 10.5% | 4912 | 24.3% |
| Myplace, Harold Hill | 10 | 0.2% | 330 | 4.5% | 4 | 0.1% | 355 | 1.8% |
| Harold Hill HC | 66 | 1.0% | 1401 | 18.9% | 45 | 0.8% | 1591 | 7.9% |
| St Kildas | 206 | 3.2% | 1136 | 15.3% | 34 | 0.6% | 1448 | 7.1% |
| South Hornchurch | 58 | 0.9% | 1100 | 14.8% | 14 | 0.3% | 1212 | 6.0% |
| Loxford | 488 | 7.5% | 58 | 0.8% | 2670 | 50.0% | 3438 | 17.0% |
| Hainault HC | 189 | 2.9% | 219 | 3.0% | 1512 | 28.3% | 2154 | 10.6% |
| Total | 6465 | 100.0% | 7414 | 100.0% | 5337 | 100.0% | 20255 | 100.0% |

* 5% of total activity is for patients resident in another non-local borough.
Source: BHRUHT

There are a number of evening and Saturday clinics and dedicated provision for young people.

## 4. The case for change

### 4.1 New technology and models of care

Commissioners across London have been working together on the London Sexual Health Services Transformation Programme (LSHTP) having concluded that innovative approaches are needed if high quality care is to be put on a sustainable financial footing.

These plans have been developed in liaison with relevant professional bodies, NHS England, Public Health England, and Health Education England, as well as service providers.

The proposed new model of care is based on a single web-based front-end for GUM services across London as a whole which, based on information provided by service user, would assess their needs and sign post to the most appropriate source of support. For asymptomatic, low risk patients this would mean the offer of a home testing kit. People testing positive for an STI will receive their results and the offer of an appointment with a clinician for treatment. Where physical attendance is required, patients will be able to book appointments on-line with local sexual health services at a

* SHRAD 2014

convenient time and location. Partners of people testing positive will be notified by a central team and invited to attend for testing themselves. Estimates of the proportion of patients that might be suitable for home testing vary between 10 and 50% of service users[†] suggesting that the needs of large numbers of patients will be met effectively, more conveniently and at lower cost.

A competitive procurement is planned to identify a provider for these London wide services to be in place by April 2017.

The corollary of adopting such a model of care is that local GUM service providers will need to reduce costs and take out surplus capacity as activity and hence their income diminishes. To facilitate the adoption of the new model, and ensure providers remain financially viable, commissioners will need to reconfigure local services to complement the London wide offer through competitive procurement or negotiation with their current provider. Given that a recent procurement failed to identify a new provider of sexual health services, reconfiguration through negotiation with the current provider is the obvious course of action locally. The recommendations contained in this paper to relocate local services are the first outputs from that negotiation.

## 4.2 Financial drivers

Sexual health services are crucial to the health of local residents and highly cost effective in terms of minimising overall costs to the public purse. Moreover, local authorities have a statutory duty to ensure adequate provision. Nonetheless, they represent a significant charge against the Public Health Allocation provided by central Government to meet the cost of all the health improvement responsibilities transferred to local government in 2013. Moreover, central Government has announced plans to cut the Public Health allocation in 2016/17 and 2017/18. As money spent on sexual health cannot be spent on other equally important priorities such as obesity or giving every child the best start in life, sexual health services must be as cost effective as possible.

**Table 3: Spend[‡] (£000s) on sexual health services as a % of Councils' Public Health Allocations**

| | 2015/16 | | | | | | | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|---|---|---|
| | Projected spend on | | | | | | | | |
| | GUM services Total | GUM services with BHRUHT | Contracptn services with BHRUHT* | All sexual health services with BHRUHT | Total spend on sexual health services | PH allocatn ** | Total spend as % of PH allocatn | PH allocatn | PH allocatn |
| LBB&D | 1641 | 1152 | 426 | 1578 | 2067 | 19200 | 10.80% | 17800 | 17400 |
| LBH | 1464 | 1016 | 483 | 1499 | 1947 | 12500 | 15.60% | 11500 | 11200 |
| LBR | 1792 | 636 | 308 | 944 | 2100 | 15600 | 13.46% | 14500 | 14100 |
| 3 borough total | 4897 | 2804 | 1217 | 4021 | 6114 | | | | |

*As most contraception services on block contract other providers don't cross charge and only spend is with BHRUHT
**Adjusted as if 0-5 services included for full year

[†] A waiting room survey undertaken by BHRUHT suggests a figure of 15%

[‡] Estimated by each borough in Jan 2016 based on year to date spend on specialist GUM and contraception services (including the cost of LARC devises). This is not the totality of Council spending on sexual health which also includes the commissioning of other contraceptive services e.g. LARC from some GPs; targeted sexual health promotion, the C-card scheme etc.

Notwithstanding the sum earned under the current PBR arrangements, BHRUT has reviewed the Sexual Health service and notified Commissioners that is a loss making at a level that cannot be sustained by the Trust.

The uncertain financial viability of the service as it is currently configured is consistent with the disappointing outcome of a procurement exercise begun by the 3 boroughs in 2014. Despite considerable effort on the part of both commissioners and potential providers, it proved impossible to award a contract for the desired service at an affordable cost.

As noted, providers are currently paid using a simple PBR mechanism. All commissioners in London are planning to introduce a more sophisticated integrated sexual health tariff (ISHT). Introduction of the ISHT will see providers being paid via a larger set of tariffs that better reflect the actual cost of the care provided in each contact rather than an average cost as is the case currently. Moreover, these tariffs have been based on the cost incurred in delivering the specific intervention in the most cost effective way possible rather than the actual costs incurred by the current local provider. An initial analysis based on 2013/14 data suggests that current income to providers across London as a whole is significantly greater than the income they could expect if the ISHT is adopted. Moreover, it appears that the impact across the BHR patch would be greater than average.

NB. All providers in London, including BHRUHT have undertaken an audit of the recording practice ahead of a further analysis of 2015/16 activity to confirm the likely impact of adopting the ISHT.

## Aims of local transformation programme

To summarise the preceding discussion, the income generated by local sexual health services is less than the cost of their provision and planned changes (LSHTP and adoption of the ISHT) are likely to reduce that income. Innovative models of care provide the opportunity to maintain quality, improve convenience and increase cost-effectiveness but only if services are redesigned.

In the circumstances, both commissioner and provider are agreed that action is needed now to ensure that: -

- The totality of services commissioned for residents, locally and London wide level, continue to meet their needs, all relevant quality standards[§] and discharge the Council's legal duty to commission open-access sexual health services
- The cost of providing local services is significantly reduced, initially to a level consistent with the income generated now and then to the lower amount likely in the medium term.

[§] in accordance with:
o Standards for the Management of Sexually Transmitted Infections, MedFASH 2014 (MedFASH, 2014 (revised and updated)) (http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf ); and
o the clinical service standards of the Faculty of Sexual and Reproductive Health Care with particular reference to Service Standards for Sexual and Reproductive Health Care, Faculty of Reproductive Health Care 2013 (FSRH, 2013b) (http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf ); and
o any, new, additional or updated national guidance and standards relating to the services contained within this specification and provision of sexual health services generally; and
o those relevant supplied elements of service defined by "Effective Commissioning of Sexual Health and HIV Services" (DH, 2003 (archived)) and "Commissioning Sexual Health services and interventions. Best practice guidance for local authorities" (DH, 2013a) (www.doh.gov.uk/publicationsandstatistics/publications/PublicationsPolicyAndGuidance/DH_407355 )

## 5. Proposals

### 5.1 Regarding the location of local GUM services

BHRUHT has advised that relocating GUM services to one site and the resulting reduction in premises costs would significantly reduce the gap between current income and the cost of providing the service.

The obvious choice is to consolidate GUM services at Barking Hospital as LBBD has the poorest sexual health and co-location with HIV treatment services there would yield additional productivity and clinical benefits. Closure of the GUM clinic at Queens would also free up space for improvements to A&E services.

On the downside, it would increase travel times such that 17% of Havering residents would be more than an hour away from GUM by public transport; 1% would be more than 70 minutes away; no one would be more than 1 ½ hours away. The longest travel times would be in the north of the borough (see maps provided as Appendix 1).

**Table 4: Travel times (mins) from stated % of output areas to nearest level 3 GUM service, any form of public transport, morning peak time period.**

| | Travelling time (mins) | LBBD | | LBH | | LBR | | 3 borough total | |
|---|---|---|---|---|---|---|---|---|---|
| | | pop'n | % of pop'n | pop'n | % of pop'n | pop'n | % of pop'n | pop'n | % of pop'n |
| GUM - current model | 0-15 | 12711 | 7% | 6996 | 3% | 0 | 0% | 19707 | 3% |
| | 16-30 | 139844 | 75% | 81820 | 34% | 65959 | 24% | 287623 | 41% |
| | 31-45 | 33356 | 18% | 120056 | 51% | 177283 | 64% | 330695 | 47% |
| | 46-60 | 0 | 0% | 28360 | 12% | 35728 | 13% | 64088 | 9% |
| | > 60 | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| GUM - Barking Hospital only | 0-15 | 12711 | 7% | 0 | 0% | 0 | 0% | 12711 | 2% |
| | 16-30 | 104359 | 56% | 10861 | 5% | 62253 | 22% | 177473 | 25% |
| | 31-45 | 59033 | 32% | 88750 | 37% | 172447 | 62% | 320230 | 46% |
| | 46-60 | 9808 | 5% | 96108 | 41% | 44270 | 16% | 150186 | 21% |
| | > 60 | 0 | 0% | 41513 | 17% | 0 | 0% | 41513 | 6% |

Data provided by TfL; analysis by LBH PHS

The advent of home testing in 2017/18 will reduce the number of residents that have to travel at all.

In addition, the development of a community based level 2 sexual health clinic in Havering and Redbridge that offers testing and treatment of uncomplicated STIs as well as contraceptive services, in line with the national definitions of level 2 services, would reduce the number of patients who are required to travel out of the borough to access level 3 GUM services.

Such a clinic would have the additional benefit to the provider of minimising any loss of activity and hence income to out-of- area providers that is likely if access to local services significantly worsens.

The relocation of GUM services to one site would also provide an opportunity to increase the number of evening clinics and dedicated young person clinics.

## 6.2 Regarding the location of family planning services

The use of multiple sites and 'pop' up clinics results in additional premises costs and the loss of considerable staff time to travelling and setting up / taking down clinics.

Consequently BHRUHT initially suggested consolidating all contraceptive services at Barking Hospital to maximise the reduction in operating costs. However, commissioners were concerned that this would unnecessarily inconvenience patients. Subsequently, BHRUHT has agreed that taken together with the closure of one GUM site; reducing the number of family planning sites to one per borough (2 in LBR, see below), with clinics provided as more or less complete days would serve to close the gap between current income and the cost of providing the service.

The impact of relocating to individual sites in each borough in various combinations has been modelled. It's evident that: -

- Barking Hospital is as well placed as any of the existing sites in Barking and Dagenham - and relocation to the site of GUM services has the additional benefit of minimising overall premises costs.
- Romford is best placed to serve Havering residents; relocation to any of the existing peripheral sites would increase travel times by significantly more.
- There's not much to choose between the 2 existing sites in Redbridge in terms of accessibility - but neither could accommodate all the clinic hours necessary to allow the other to close.

Nonetheless, adopting a 4 site model would also increase travel times for residents. Residents in the periphery of Havering would have the longest journey (see Appendix 1).

**Table 4: Travel time (mins) to nearest family planning clinic under stated scenarios**

| | Travelling time (mins) | LBBD | | LBH | | LBR | | 3 borough total | |
|---|---|---|---|---|---|---|---|---|---|
| | | pop'n | % of pop'n | pop'n | % of pop'n | pop'n | % of pop'n | pop'n | % of pop'n |
| FP - current model | 0-15 | 57665 | 31% | 41074 | 17% | 38518 | 14% | 137257 | 20% |
| | 16-30 | 116818 | 63% | 148020 | 62% | 132029 | 47% | 396867 | 57% |
| | 31-45 | 11428 | 6% | 48138 | 20% | 108423 | 39% | 167989 | 24% |
| | 46-60 | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| | > 60 mins | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| FP - Barking Hospital only | 0-15 | 12711 | 7% | 0 | 0% | 0 | 0% | 12711 | 2% |
| | 16-30 | 104359 | 56% | 10861 | 5% | 76452 | 27% | 191672 | 27% |
| | 31-45 | 60650 | 33% | 95285 | 40% | 168911 | 61% | 324846 | 46% |
| | 46-60 | 8191 | 4% | 107297 | 45% | 33607 | 12% | 149095 | 21% |
| | > 60 mins | 0 | 0% | 23789 | 10% | 0 | 0% | 23789 | 3% |
| FP - preferred 4 site model | 0-15 | 22180 | 12% | 6996 | 3% | 38518 | 14% | 67694 | 10% |
| | 16-30 | 137882 | 74% | 83393 | 35% | 132029 | 47% | 353304 | 50% |
| | 31-45 | 25849 | 14% | 123215 | 52% | 108423 | 39% | 257487 | 37% |
| | 46-60 | 0 | 0% | 23628 | 10% | 0 | 0% | 23628 | 3% |
| | > 60 mins | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |

Data provided by TfL; analysis by LBH PHS

A four site model appears to be practicable and offer the best balance between reducing service costs and maintaining accessibility.

BHRUHT with assistance from LBH is looking for a suitable site in Romford for a stand-alone level 2 service. As yet, none has been identified. Until one has been found, the new model of service (i.e. contraception services plus testing and treatment of uncomplicated STIs) would be sited at Queens.

## 6. Care pathways, models of care and implications for staffing.

This paper outlines proposals for the redesign of services in terms of location. Of equal, if not greater importance, are the care pathways employed and the clinical team required to deliver them cost effectively and to a consistently high standard. A parallel process to review and redesign the pathways and models of care employed is essential if the service is to be put on a sustainable financial footing in the longer term as salaries make up more than half of the overall costs of service provision. This process will be led by senior clinicians within the service itself drawing on the work previously undertaken to inform the development of the ISHT[**].

## 7. Summary of current status and recommendations for change

BHRUHT currently incur a significant and unsustainable financial loss in providing local sexual health services. Planned developments across London will reduce attendances at GUM services and the gap between provider income and the cost of services will grow still further. GUM activity could be accommodated more cost effectively at one site. Barking Hospital would be preferable as need in LBBD is higher; co-location with HIV services there would yield additional benefits and the clinic space freed up at Queens Hospital would enable further improvements to urgent care. Travel times would increased but the number of people inconvenienced will fall when home testing is made available for suitable patients and if testing and treatment for uncomplicated STIs were to be provided from level 2 services.

Level 2 services currently only offer contraceptive care. Clinics are provided at multiple sites for short periods as a result considerable clinician time is wasted. Consolidation on fewer, ideally one site in each borough would be much more cost effective. Again this would result in increased travel times. However, general practice is very accessible and is the preferred provider of contraception for the majority of women.

Given the above, it is recommended that LBBD, LBH and LBR as commissioners of local sexual health services and BHRUHT as provider take the following steps: -

[**] http://www.pathwayanalytics.com/sexual-health/231

1. Consolidate local level 3 GUM services at Barking Hospital and increase provision for Young Persons and out of normal working hours.
2. Limit the inconvenience caused by increased travel times by ;
    a. Offer testing and treatment of uncomplicated STIs at level 2 services
    b. Commission home-testing for asymptomatic low risk patients.
3. Provide a full range of contraception services from one or at most two level 2 sites per borough. The level 3 hub at Barking Hospital will cater for the small proportion of patients with complex contraceptive needs. The service as a whole will continue to offer clinics for young people and out of normal working hours. Level 2 sites will be accessible and located to best serve the whole borough i.e.
    a. In Havering, in Romford – clinic space will be provided at Queens until a suitable site in the community is identified
    b. In Barking and Dagenham, at Barking Hospital
    c. In Redbridge, at the 2 existing centres until and unless a single site is identified that better serves the whole borough
4. In addition, the 3 Councils and BHRUHT should work
    a. to establish a single board with representation from other relevant stakeholders including BHRCCGs to oversee the continued redesign of local sexual health services
    b. with GPs and community pharmacists to maintain and improve the provision of contraceptive services in primary care.

## References

[1] Department of Health. A Framework for Sexual Health Improvement in England. 2013. https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
[2] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/351/regulation/6/made
[3] All Party Parliamentary Pro-Choice and Sexual Health Group, A report into the delivery of sexual health services in general practice, October 2007.