



Public Health
England

Protecting and improving the nation's health

Sexual Health, Reproductive Health and HIV

A Review of Commissioning

About Public Health England

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Published August 2017

PHE publications

gateway number: 2017317

PHE supports the UN

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Acknowledgements

I would like to thank those who contributed to the design and analysis of the survey and the preparation of this report. To Professor Jane Anderson, Dr. John Saunders, Wendi Slater and Alice Stonham in the design and analysis of the survey. To ADPH, NHS England and NHS Clinical Commissioners for their support and cooperation. To PHE Sexual and Reproductive Health and HIV Programme Board for their support.

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Foreword

Good sexual and reproductive health and wellbeing is an important contributor to our overall wellbeing. The quality of sexual and reproductive health and HIV services rely in part on effective commissioning.

"Sexual Health, Reproductive Health and HIV: A Review of Commissioning", identifies the commissioning challenges faced by commissioners and providers. These range from tackling sexual and reproductive health and HIV in a co-owned strategic way to the complexities of multi commissioners dealing with open access services. The report has analysed the responses from across the country and as well as reporting the findings, makes recommendations designed to support and improve commissioning. Amongst its recommendations the report proposes that the most effective way of commissioning relies on coordinated cross-sectorial working that delivers joined-up care pathways, together with a jointly owned strategic plan for service provision.

PHE and the Association of Directors of Public Health thank those who responded to the survey. It is through these responses that PHE has been able to compile an overall picture of commissioning and to develop an action plan to respond to the challenges identified. Amongst its recommendations the report supports the development of models for collaborative commissioning of sexual and reproductive health services. London has shown us something of the progress that can be made. The pilots and the other actions outlined in this report will further develop models to fit other scenarios. There is unlikely to be a one-size-fits-all solution and the local context remains fundamental.

All commissioners should aspire to the sort of services we'd be happy for our own families to use.



Duncan Selbie Chief Executive
Public Health England



Andrew Furber President
Association of Directors of Public Health

Executive Summary

1. The variability in implementation of the commissioning arrangements introduced for sexual and reproductive health and HIV has been the subject of comment and concern since their introduction in April 2013. The issues have been the subject of debate amongst commissioners and providers, Parliament (both by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK and the Health Select Committee), and medical colleges and health institutions. What has been lacking however is a comprehensive systematic analysis of all aspects of commissioning, encompassing services commissioned by local government and the NHS across the wide spectrum of sexual and reproductive health and HIV.
2. PHE decided in 2016 to work with key partners to undertake a survey of commissioning in order to provide a clear picture and to highlight areas of challenge within the commissioning framework.
3. In 2016 PHE undertook with the Association of Directors of Public Health (ADPH), and supported by NHS England and NHS Clinical Commissioners, a survey of local authorities, NHS England and Clinical Commissioning Groups (CCGs). The survey received excellent response rates from local authorities, and a good rate from NHS England. However CCG responses were extremely low and required further work to obtain analysable data.
4. The responses received have been analysed and, following further discussions with commissioners, have led to the conclusions reached in this report. The findings form the basis of an action plan that is published within the report.
5. PHE has seen some excellent work in improving services, recasting service specifications to meet assessed needs and examples of collaborative approaches – particularly in London. However it has also found evidence of structural concerns which have the potential to impede effective commissioning. The report identifies these areas as reported to it through the survey and focuses on ways to support the commissioning process and improve its effectiveness.
6. The main findings from the survey are:
 - fragmentation of commissioning
 - ensuring access to services, particularly for those at greatest risk
 - contracting problems including cross-charging for patients attending services outside of area
 - workforce concerns – clinical expertise both in service delivery but also in commissioning

- increasing demand for some services
 - financial pressures due to reductions in budgets – particularly in local authorities
7. Having identified key issues from the analysis, PHE has conducted discussions with relevant partners and identified specific areas where action is required to support the commissioning of sexual health, reproductive health and HIV. The actions are based on the assumption that there will be no fundamental change to the commissioning model which would potentially require primary or secondary legislation and that current responsibilities of commissioners will remain as they are. The actions require the cooperation of commissioners and input from Department of Health, as well as work from PHE. There are also key leadership requirements for national system leaders.
8. The actions fall into five main categories – these are:
- reduce fragmentation of commissioning and reduce contracting barriers
 - support commissioners in the delivery of effective commissioning
 - build capability in commissioning
 - provide evidence and data to support commissioning and the monitoring of outcomes
 - ensure that sexual health, reproductive health and HIV commissioning is explicitly considered within the development of the new funding mechanisms for public health over the next three years
9. PHE believes that strengthening commissioning through these areas will have benefits for services, enable co-designed strategies across clinical pathways to be developed, introduce more efficient contracting and give clarity to providers.
10. Improving the commissioning process is not a panacea, it will only go so far in improving clinical outcomes. There is a need to look carefully at a wide range of issues, including how to affect behavioural change, targeted use of marketing, tackling skills shortages in clinical staff and ongoing education. Leadership across the system - within clinical communities and nationally, within local authorities, NHS England, CCGs and providers - is essential. Without improvement in this wider environment, changes in commissioning will not deliver the step-change that is required to alter some of the negative trends and to accelerate those that are going in the right direction but have not reached the levels we would like when compared with international comparators. To address this, PHE has worked with partners to produce a plan of action for sexual and reproductive health and HIV which addresses the wider fundamental issues.

Methodology

11. This section:

- outlines the methodology used to design and implement the survey
- describes the analytical process

12. In February 2016 PHE, together with ADPH, NHS England and NHS Clinical Commissioners, launched a review of sexual, reproductive health and HIV commissioning. The survey was developed in collaboration with partner organisations and was tested and revised before being issued.

13. The structure of the survey was based on the commissioning steps set out in “A guide to whole system commissioning for sexual health, reproductive health and HIV”. Additional themes were agreed following discussion with partner organisations and commissioners.

14. The survey was produced as a set of on-line tools – with a slightly different survey for each of the three commissioners reflecting their commissioning processes and responsibilities. The surveys were distributed via ADPH (local authorities), within NHS England and through NHS Clinical Commissioners to CCGs. In order to promote open and honest responses and to encourage as many as possible to respond, a commitment was provided to commissioners to only publish anonymised aggregated information.

15. Information on completion and a link to access the survey tool was provided to respondents. When an organisation accessed the survey a unique code was generated, which enabled multiple entries from across a single organisation – reflecting the complexity of commissioning. The final survey for each was submitted after sign off by a senior member of the organisation. On-line support for fielding queries was via a dedicated inbox with queries being turned around within 48 hours.

16. Analysis of the results was carried out by the Directorate of the Chief Knowledge Officer within PHE. Each sector’s responses were analysed separately. Consistent themes were identified. Examples of good practice were logged.

17. The response rates varied dramatically between commissioning sectors. The highest response rate came from local authorities with 103 of the 152 upper tier authorities (68%) responding. NHS England had a response

rate of 31% and CCGs the lowest response rate of 1% (2). Given the low response rate by CCGs, the review team first extended the deadline for responses and when this did not produce further responses, the survey was reissued. Neither of these approaches produced responses. The team, therefore, approached CCGs directly through their centres' sexual health leads and facilitators and were able to increase the sample to 25 plus a composite response across London.

18. From the analysis a report was prepared. The key findings were shared with commissioning organisations at a national level and discussion began on the production of an action plan to support the key issues. This report provides a narrative and the detailed findings together with a proposed way forward.

Discussion

19. In 2013, new commissioning arrangements for sexual, reproductive health and HIV were introduced as part of the implementation of the Health and Social Care Act 2012. Local government responsibilities for sexual health services were further detailed in 'The Local Authorities (Public Health Functions and entry to Premises by Local Healthwatch Representatives) Regulations 2013'. There are currently three sets of organisations responsible for commissioning different elements of local sexual health services: local authorities, NHS England and CCGs. The majority of services are commissioned by local authorities. Each of the commissioners became responsible in 2013 for a portfolio of services. These can be summarised as:

- **Local authorities**
 - contraception
 - STI testing and treatment
 - sexual aspects of psychosexual counselling
 - sexual health specialist services
 - HIV social care
 - wider support for teenage parents

- **NHS England**
 - some contraception services
 - HIV treatment and care
 - testing and treatment for STIs in primary care (including HIV)
 - sexual health in secure and detained settings
 - sexual assault referral centres
 - cervical screening
 - HPV immunisation programme
 - specialist foetal medicine services
 - NHS infectious diseases in pregnancy screening

- **Clinical Commissioning Groups**
 - abortion services
 - female sterilisation
 - vasectomies
 - non-sexual aspects of psychosexual services
 - contraception for gynaecological purposes
 - HIV testing for specified services

20. Whilst some of these services are relatively discrete, there is significant overlap in others. Some services are provided by the same organisation and their interdependencies are critical for the combined service provision offered.
21. In 2013 the Department of Health published a framework for sexual health improvement. This included the aim of reducing inequalities and improving the position in four priority areas:
 - reduce STI rates
 - reduce HIV transmission rates and avoidable deaths
 - reduce unwanted pregnancies
 - continue to reduce 'under 16 and 18' conception rates
22. These remain key challenges for the local sexual health service especially with issues about the termination of pregnancy services and provision of PrEP.
23. In 2014/15 PHE, with the support of the Department of Health, the Local Government Association, the Association of Directors of Public Health and NHS England, produced 'Making it Work, a guide to whole system commissioning for sexual health, reproductive health and HIV'. This set out ways by which the three commissioners could work in an integrated way ensuring coherent and coordinated commissioning of services. The guide was based on the premise that the best services for the public and thus impact on outcomes would come from commissioners working together to commission for the whole local sexual health system – co-commissioning.
24. Concerns have been reported since the new arrangements were put in place, predominately by providers but also by those directly involved in commissioning. Those raising concerns believe that the model introduced in 2013 has led to a fragmentation of commissioning responsibilities and a lack of 'joined up' services for local people. In 2015, similar concerns were raised by the All Party Parliamentary Group on Sexual and Reproductive Health. The Health Select Committee also concluded that the system was fragmented in its recent review, 'Public Health post 2013'.
25. There has been no nation-wide systematic analysis of the commissioning arrangements put in place in 2013, and so PHE decided to undertake a review of the commissioning model. The review was designed and carried out with the Association of Directors of Public Health, and the support of NHS England and NHS Clinical Commissioners – as well as the engagement of other key partners including the Department of Health and the Local Government Association. The local authorities, NHS England and CCGs each completed an online survey tool based around the commissioning cycle described in 'Making it Work'. The questions were both quantitative and qualitative.

26. Since the review by PHE was started in 2016, there have been some aspects of the commissioning model examined and reported on.
27. In December 2016, the All-Party Parliamentary Group on HIV and AIDS in the UK published a report into HIV Care. The report entitled 'The HIV Puzzle'¹ was based on a wide range of representations from stakeholders. It concluded that there was fragmentation of commissioning for HIV and that this had had a detrimental effect on patients and HIV providers. It also highlighted the benefits of HIV being co-commissioned with sexual and reproductive health services.
28. In March 2017, the King's Fund published a report 'Understanding NHS Financial Pressures – how are they affecting patient care?'². This report highlighted a growing fragmentation in services to patients – for example the move from co-located GUM services and HIV clinics as a consequence of tendering and a similar issue where GUM and contraceptive clinics have been uncoupled.
29. In July 2017 the Royal College of General Practitioners published its own assessment, resulting in its paper 'Sexual and Reproductive Health: Time to Act'³. The report, based on polling of members in October 2016 raised the problems of reduced availability of LARC in primary care, the difficulty of retaining training qualifications and of training the next generation.
30. These reports demonstrate and evidence concerns about aspects of the commissioning picture for sexual and reproductive health and HIV. The PHE survey has been designed to look at the commissioning process across the framework. The collection of data was carried out during 2016 and, not surprisingly, shows consistency with findings in these reports.
31. The responses from the PHE survey were analysed and the output can be found at **Appendix 1** of this report. This provides a question by question response to the survey where possible. The most comprehensive section is that provided by local authorities, which represents the majority of sexual health services commissioned.
32. From the responses, key issues were identified and the findings tested with commissioners. The consensus was that the findings were an accurate

¹ 'The HIV Puzzle: Piecing together HIV care since the Health and Social Care Act'. The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK . Published December 2016.

² 'Understanding NHS Financial Pressures – how are they affecting patient care?'. Authors: Ruth Robertson, Lillie Wenzel, James Thompson, Anna Charles. The King's Fund. Published March 2017. ISBN: 978 1 909029 70 5.

³ 'Sexual and Reproductive Health: Time to Act'. Royal College of General Practitioners. Published July 2017.

representation of the overall position. There are of course variations to the overall position but in the main the messages are consistent – both by geography and by rural/urban split.

Findings

Key Themes from the Survey

33. Amongst the wealth of information provided by commissioners, there were six key themes that were consistently reported and have been considered of note. These were:

- fragmentation of commissioning
- ensuring access to services, particularly for those at greatest risk
- contracting problems including cross-charging for patients attending services outside of area
- workforce concerns – clinical expertise both in service delivery but also in commissioning
- increasing demand for some services
- financial pressures due to reductions in budgets – particularly in local authorities

Fragmenting of Commissioning

“The split commissioning of Sexual Health Services across local authority, CCGs and NHSE England has meant that seamless pathways and well established partnership have been challenged tremendously in order to sustain and develop service provision.”

34. That commissioning for Sexual and Reproductive and HIV Commissioning is ‘complicated’, ‘complex’ and ‘fragmented’ was raised frequently as an area of concern. Respondents reported commissioning in silos, with inadequate communication and a lack of clarity as to who was responsible for what, in particular geographical areas and cross boundary service. Leadership both in terms of commissioning and clinical services varied and in some cases was unclear. Co-ordination, expertise and capacity were often dependent on historic arrangements and individuals who had previous experience in sexual health commissioning.

35. Fragmentation was often exacerbated by a lack of collaborative working between commissioners and between commissioners and providers. Service pathways were not clear. Key challenges identified included:

- having to deal with a significant number of organisations
- competing priorities between commissioners
- lack of commissioning guidance
- in primary care, variations in engagement over the provision of contraception and cervical screening

“Engaging with other commissioners responsible for sexual health – this is a small part of their responsibility so importance placed on it is often limited”.

36. Whilst this issue was primarily raised by local authorities they were echoed in the responses from other commissioners – particularly CCGs. CCGs highlighted three key concerns:

Difficulties in delivering seamless care

CCGs identified difficulties in delivering seamless care due to fragmented commissioning and a lack of capacity. Examples of services where this occurred included:

- HIV and hepatitis
- STD clinics
- mental health – stress and psychosexual counselling
- termination of pregnancy
- the interface between acute and community services

Joint working

Joint working does occur in many areas across the country. However it is not universal. In a separate piece of work, PHE has looked at whether there are any examples of collaboration between all three commissioners. With the exception of two areas, no examples were found. There are examples where local authorities have come together, some examples of local authorities’ and CCGs’ collaboration and some examples of collaboration with NHS England; however little evidence was found of systematic collaborative working across all three sectors.

Problems with service quality and meeting population needs

Population needs not being met was highlighted. This was linked to quality of provision ie commissioning for vulnerable groups and outreach services for schools/colleges.

The overall picture presented by the survey is one of fragmentation. This was not unanticipated – three commissioners each commission elements of the service: they cover differing geographical areas; have differing priorities, capacity and resources. There are, however, a number of very successful arrangements where co-operation has led to clear approaches and have been instructive in the development of the proposed actions identified later in the document.

Access to Services: Particularly for those at Greatest Risk

37. Issues identified with regard to accessing services fall into two categories:

Access by vulnerable groups

Local authorities identified vulnerable groups for whom they had undertaken needs assessments. Needs assessment for sexual health services at a generic level was reported as high, with 88% of local authorities having conducted needs assessments in the previous three years. The response shows 7% of those local authorities responding had conducted a needs assessment for sexual health specifically for people with mental health problems, 10% for homeless people, 12% for victims of sexual assault and 16% for drug and alcohol users. Other categories identified, where some assessment had been conducted, were for migrant workers and over-50s. Consideration has been given to how needs assessment for vulnerable groups can be supported. PHE will, as part of its response to this document, produce guidance on this aspect of commissioning as part of a guide tackling some of the more significant issues raised by the survey.

Access in rural areas

Rural areas and large diverse geographical areas were identified as a challenge – in terms of access and cross-boundary flows to neighbouring authorities. Similar challenges were identified for certain high risk populations – including MSM and BME. Provision of local services particularly in rural areas was seen as a problem, as was accessing suitable premises to base services. This aspect of the feedback to the survey was not expressed in detail but will be an interesting area to explore going forward.

Contracting

“A fixed budget with an open access service (GUM/CaSH) is highly problematic as usage increases. The administration behind cross-charging arrangements is time consuming and a drain on council resources.”

38. There were some issues raised by CCGs and NHS England relating to contracting – mostly linked to co-commissioning, timing of retendering and capacity. However, the most significant contract process issues were identified by local authorities. They reported concerns about:

- out of area payments
- local payment approaches
- local tariffs and specifications leading to potential payment disputes over out-of-area patients
- variable reporting requirements placed on providers
- budget management for open-access clinics
- uncoordinated tendering processes leading to multiple tendering exercises for providers and potential impact on provider viability
- increasing demand for services – both in range and numbers of people accessing the services

39. Of these concerns the one that was highlighted most frequently was that of managing out-of-area payments. The current commissioning system allows local authorities to construct local specifications and tariffs. Whilst there are national models on which authorities can draw they can, and do, define specifications locally. This provides local flexibility to enable a service to be designed that meets local needs, but causes difficulties when patients access services from another authority with a different tariff. This has generated an administrative burden that can lead to disputes between commissioners.

40. There are examples, most notably in London, where a collaborative approach to contracting as part of a joint commissioning system has been developed. A collaborative approach that recognises patient flows and secures agreements – either in terms of common service specification, or explicit arrangements for the management of out-of-area flows - can reduce the administrative burdens associated with this kind of patient activity. A combination of local co-commissioning, and national guidance could have a potentially significant impact on improving commissioning. There are many differing models of how this can be applied but co-commissioning and collaboration by all commissioners offers an efficient way forward.

41. Coordination between commissioning sectors can improve the effectiveness of the contracting process. There are examples where joint tendering processes have been developed and used. These reduce the administrative burden on

providers and ensure that tendering is synchronised to ensure that unintended adverse consequences are not created. In discussions with commissioners examples of where tendering of services by one commissioner has impacted on the viability of a wider service commissioned by another party have been reported. In such cases collaboration would have reduced the risk of a potential service reduction as an unintended consequence and could afford the opportunity for viable, mutually agreed pathways to be designed and maintained.

42. Commissioning along service pathways can be complex and the fragmentation discussed earlier can exacerbate the difficulties. There are good examples of where there are effective mechanisms for strategic discussion and service development. These should enable a multi-sectorial strategy to be developed that supports and directs the contracting process. Many local sexual health forums exist and perform this kind of function but in most cases not all of the sectors are represented/attend. There is also confusion about leadership and clarity lacking over what precisely each sector is responsible for. Further guidance or a reissuing of existing guidance to clarify roles and responsibilities could be considered. Clarity in this area would certainly support effective commissioning.

Workforce

43. There were concerns raised about the clinical workforce, although this was not as widely raised as fragmentation and contracting issues. The key themes identified were:
- vacancy levels in GUM, SRH and general practice
 - knowledge and training in some providers to provide LARC
 - managing fundamental change and a reluctance of clinicians to collaborate or lead the process
44. The concerns about vacancies related in the main to the quality of service provision and to the long-term sustainability of clinical services. There is further work required to understand the issues fully, but the issue is of sufficient concern that a key action for PHE and partner organisations will be on building capacity and capability. Within this will be work to identify more clearly the issues and produce plans to address these needs.
45. PHE believes there is merit in strengthening both local and national clinical leadership within commissioning. Building on the excellent work already underway in some parts of the country, it proposes to work with clinical leaders – such as ADPH and the Faculty of Reproductive and Sexual Health as well as other key organisations - to develop a framework for sector/system led improvement activity and to facilitate and support the further development of sexual health, reproductive health and HIV networks. PHE believes that the approach adopted in London should be reviewed and key learning from the

process made available to the rest of the country. This approach, whilst not necessarily applicable everywhere, has much that can be used to develop a more comprehensive approach to co-commissioning.

Increasing Demand

46. Respondents to the survey who expressed an opinion on this issue raised concerns about two key factors:

- a decrease in capacity
- an increase in demand

47. Commissioners commented that decrease in capacity was, in their view, due to a complex interaction between funding, commissioning and workforce. They saw it in both primary care and specialist services. This is an important issue which requires further investigation so that the key barriers can be identified and resolved.

48. Areas of demand identified as those likely to increase were:

- Chemsex
- PrEP
- HPV vaccination for men

49. The consequences identified by commissioners were:

- a worsening of health inequalities
- LARC and cervical cytology might suffer
- a move away from prevention with resources focused on treatment
- consequential reputational damage

Financial Pressures

50. Whilst all commissioners had concerns about future funding, concerns were most pronounced in local authorities. The previous cut in the Public Health Grant was a recurring concern. Analysis of the figures would indicate that there has been a reduction in spend of the Public Health Grant of 2.1% between 2013-14 and 2015-16. This is in line with the 2.3% overall grant reduction. Within these headline figures there has been a realignment of spend with a decrease of 8% on STI treatment and testing but increases in spend on contraception and promotion and prevention.

51. Respondents to the survey expressed concerns about the impact of future cuts and whether current provision was sustainable. Local authorities described moves to reduce access to specialist services and redirect those requiring less specialist care to GPs and pharmacies. This is dependent on capacity in primary care which in turn requires effective co-commissioning to ensure that capacity is available and models across the pathway are effective. Given the lack of effective cross-sectoral commissioning reporting, this must be challenging and may lead to unintended consequences for partner commissioners.
52. There was also uncertainty expressed as to the future of the funding associated with the Public Health Grant. Some recognised and welcomed the additional flexibility this would give – but there was concern that resources would not be maintained for sexual, reproductive health and HIV services.
53. The discussions on future funding mechanisms for public health are far wider than sexual health. However, the importance of it as part of the Public Health Grant needs to inform the ongoing national discussions on funding.

The Way Forward

The results of the survey demonstrate some significant challenges facing commissioners. The current commissioning mechanisms are a result of the 2013 health and care reforms. The fragmentation of the system arising from the changes to commissioning responsibilities challenge commissioners and rely on local co-operation/collaboration. However, the new structures have also brought significant benefits and these should not be discounted.

The structure is complex and was designed to meet the need to deliver a range of models across three sectors for services with complex inter-dependencies:

- local authorities took on the responsibility for comprehensive sexual health services enabling closer integration of sexual health with other services they commission
- NHS England has a critical role in commissioning HIV testing and contraception services and through the Section 7A Agreement, which covers a range of public health services
- CCGs also commission HIV testing and have responsibility for abortion services and sterilisation

54. With three sectors all having varying elements of services for which they are responsible, fragmentation has always been a concern. The importance of co-operation between services is critical for effective strategic planning and collaborative commissioning. This has not happened. Ten per cent of commissioners have reported co-commissioning in some form. Further work shows that where there is co-commissioning it is predominantly with one sector (often local authorities) or in some cases two sectors. Many reflect pre-change (2013) arrangements and build on a history of close working across sectors. Engagement with CCGs remains the greatest challenge.

55. Where collaboration is being considered, engagement with all three commissioning sectors remains problematic. Local authorities may be reluctant to work with adjoining local authorities, NHS England's structures may not assist in local commissioning discussions and capacity and/or capability in CCGs is often limited.

56. When these issues are combined with a local contracting model within local authorities, boundary complexities arising from out of area patients and a lack of pre-agreed arrangements between commissioners, the risk of disputes is high.

57. From a provider's perspective, they face constant uncertainty and regular rounds of re-tendering. Elements of provision are tendered at different times by different commissioners, and the possibility of a loss of part of a service making the entire service untenable can be very real.
58. The need to maximise the return on investment in an environment where resources are reducing is challenging and with the future changes to the funding of the Public Health Grant there will be even more pressure on local authorities to scrutinise spend on all public health services.
59. Within the commissioning process there continues to be a need to support and provide advice/guidance: for example, need assessments for minority and hard to reach groups, benchmark data to support improvements and allow for best practice to be spread across and between sectors.

The Proposed Way Forward

60. The results of the survey have been discussed with the commissioners – local authorities, NHS England and CCGs – together with key partners, including ADPH, LGA, NHS Clinical Commissioners, provider and interest groups including The British HIV Association, the British Association of Sexual Health and HIV, Faculty of Reproductive and Sexual Health and the Royal College of Obstetrics and Gynaecology. The findings have not been disputed and there is an acceptance that a more co-ordinated and collaborative commissioning model is needed. This however needs to reflect local circumstances and methods of working.

61. PHE has considered the position and is proposing that some key actions are taken to support and improve commissioning. It has accepted that the current model of commissioning will remain and that the contracting arrangements underpinning that model will continue. PHE is therefore proposing six actions to improve commissioning. These are:

- developing a model of ‘lead integrated commissioning’ in each locality, including developing models for out of area tariffs
- testing two models of local delivery based on examples of local practice to assist in the effective commissioning of sexual health, reproductive health and HIV
- revising and enhancing current commissioning guidance, including a new service specification for pregnancy and termination of pregnancy services
- facilitating the development of sexual health networks across the country to address pan-organisational issues, such as ‘cross boundary flows’
- developing a framework for sector-led improvement for sexual health services that is consistent with the wider work on sector-led improvement
- enhancing data and other commissioning support tools

National Piloting of Collaborative Cross-Sectoral Commissioning

62. ‘Making it Work’ described the benefits of co-commissioning and the survey has concluded that cross-sectoral collaborative commissioning is the most effective model.

63. Such a model needs to build on strong foundations. These are:

- identified clinical and managerial leadership
- recognising patient flows across administrative boundaries
- consistent approaches to commissioning and contracting

- a strategic plan agreed across all three commissioning sectors - based on best practice and designed to deliver maximum return on investment

64. To this end, PHE will be supporting, together with national partners (ADPH, NHS England, NHS Clinical Commissioners) a national pilot scheme designed to support and evaluate the development of two cross-sectional commissioning collaborations. Two pilot sites have already been identified.

65. These pilots will provide the opportunity to examine local models led by different commissioning organisations but based on the foundations described above.

66. In addition, those areas already involved in collaboration will be approached to share their experiences and learning.

Supporting the Commissioning Process

67. The survey identifies areas where support to the commissioning process would be beneficial.

68. These fall into three distinct categories:

- strategic planning and assessing need
- designing and delivery of interventions
- monitoring and evaluation

69. For each of these elements of the planning cycle, the survey identified areas where further support, information and access to model interventions would benefit effective Commissioning.

70. In the case of strategic planning and assessing need, data and information on current provision, outcomes and advice on assessing the needs of hard-to-reach groups and areas of unmet need were identified. The debate on the design and delivery of interventions has raised issues, these are:

- effective contracting
- integrated service design and the need for better intelligence of the effectiveness of interventions
- the return on investment (ROI) of such intervention

71. Ease of access to and effective use of data to support monitoring and evaluation, as well as assisting the development of future strategic planning and assessment of need, are also key.

72. In response, it is proposed that further information is provided by PHE to Commissioners to support the effective commissioning of services. The advice will be designed and issued during 2017 in conjunction with partners and is intended as a supplement to the advice laid out in 'Making it Work'.

Revise Commissioning Guidance

73. Concern was expressed that current guidance on commissioning of sexual health, reproductive health and HIV services is inadequate and confusing. Whilst this was not a universally held position, it is sufficiently consistent as a message to warrant review. There is already work underway in this area – particularly in the areas of pregnancy and termination of pregnancy services. Further work will be considered with the aim of providing clear guidance and service specifications. In addition, PHE will use the findings of the survey and the identified areas where help will assist in improving commissioning and produce a further good practice guide for commissioners. The guide will focus on:

- addressing the key issues arising from the survey
- provide advice and examples of locally designed system solutions
- provide case studies and reference material that describes actual experiences from across the country

74. PHE will work closely with partner organisations in the development of this guidance.

Facilitate and Support Sexual Health, Reproductive Health and HIV Networks

75. Whilst there are networks in many areas of the country, they vary in size, scope and membership. The survey has shown the lack of commissioner collaboration and an absence of managerial and clinical leadership. PHE will map existing networks and, together with networks, look at function, form and geography and develop a national infrastructure for networks to interact, to share learning and to discuss common issues as they arise. PHE will also assess how best to link local clinical expertise from service providers with commissioning and whether a national forum is beneficial.

76. Cross boundary flows remain a major contractual issue, with different tariffs, data sets and specifications leading to disputes between commissioners and providers. In response, PHE believes that guidance in this area should be

reviewed. In addition, networks should review local arrangements and agree in advance measures to solve cross-boundary disputes, as well as dispute resolution processes.

Sector Led Improvement

77. Local government is responsible for managing its performance through Sector Led Improvement (SLI). This process will include sexual and reproductive health and, given the fragmented arrangements of the commissioning arrangements, should interface with NHS improvement arrangements to ensure system-wide improvements can be delivered. Consideration should be given as to ways to build on or complement SLI to ensure system led improvement in this area is adopted.

Enhance Data and other Support Tools

78. One of the areas identified in the survey where further help from PHE was requested is data. This included further tools, data sets, analysis and specific reports. Extensive information is provided by PHE in the form of:

- sexual and reproductive health profiles
- LASERS (Local Authority Sexual health Epidemiology Reports)
- web portal data and information

79. PHE recognises the key need for information in support of commissioning. PHE will continue to provide a wide range of data and information resources and will support this by working with commissioners to ensure that the tasks which are often complex are fully understood.

80. PHE will also review how it publishes its data with a view to provision of open and transparent information where possible. PHE will also look at how it can produce customised briefings to support commissioners in their local debates on various interventions, including:

- return on investment (ROI) from prevention initiatives
- impact on place of effective sexual health, reproductive health and HIV provision
- suitable topic specific briefings to provide key information to inform commissioning – eg MSM, PrEP and reproductive health

GLOSSARY OF TERMS USED

ADPH	Association for Directors in Public Health
BASHH	British Association for Sexual Health and HIV
BME	Black and minority ethnic
CaSH	Contraception and Sexual Health eg CaSH clinics
CCG	<p>Clinical Commissioning Group. Most of the NHS commissioning budget is now managed by 209 clinical commissioning groups. These are groups of general practices which come together in each area to commission the best services for their patients and population.</p> <p>CCGs and NHS England are supported by commissioning support units (CSUs). Their role is to carry out:</p> <ul style="list-style-type: none"> • transformational commissioning functions, such as service redesign • transactional commissioning functions, such as market management, healthcare procurement, contract negotiation and monitoring, information analysis and risk stratification
Chemsex	Gay or bisexual men using drugs to facilitate sex with other men
DOH/DH	Department of Health
EHC	Emergency hormonal contraception
GUM	<p>Genito urinary Medicine. Genito urinary clinics offer a range of options:</p> <ul style="list-style-type: none"> • testing and treatment for sexually transmitted infections (STIs) • advice and information about sexual health • free condoms • contraception – including emergency contraception, such as the morning after pill • pregnancy testing • HIV testing – including rapid tests that give results in about 30 minutes and counselling for people who are HIV-positive • PrEP (post-exposure prophylaxis) – medication that can help

	<p>prevent people from developing HIV if they have been exposed to it</p> <ul style="list-style-type: none"> • hepatitis B vaccination • advice about abortion • help for people who have been sexually assaulted • if necessary, a referral to a specialist
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
KHub	LGA Knowledge Hub. The Local Government Association Knowledge Hub provides secure online knowledge sharing for councillors and officers to connect and communicate with peers across local government.
LASERS	Local authority sexual health epidemiology reports. These reports are produced by PHE on an annual basis. The aim of these reports is to describe STIs, HIV and reproductive health in the local area to inform joint strategic needs assessments so that commissioners can effectively target service provision. They provide local level data on STIs, including chlamydia and HIV, as well as clinic access and service use, with analyses and breakdowns by small geographical area (MSOA) and key STI prevention groups. Data on contraception provided by SRH services and general practices, as well as some conception and abortion statistics, were included later.
LARC	Long acting reversible contraception
LGA	Local Government Association
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex
MSM	Men having sex with other men
NCSP	National Chlamydia Screening Programme. The aim is to control chlamydia through early detection and treatment of asymptomatic infection, so reducing onward transmission and the consequences of untreated infection.
NHSE	NHS England is an independent body, at arm's length to the government. Its main role is to set the priorities and direction of the NHS and to improve health and care outcomes for people in

	<p>England.</p> <p>NHS England is the commissioner for primary care services such as GPs, pharmacists and dentists. Nationally, NHS England commissions specialised services, primary care, some public health services, offender healthcare and some services for the armed forces.</p> <p>As part of the NHS Five Year Forward View, primary care co-commissioning was introduced. An example of this is NHS England inviting Clinical Commissioning Groups (CCGs) to take on an increased role in the commissioning of GP services.</p> <p>NHS England manages around £100 billion of the overall NHS budget and ensures that organisations are spending the allocated funds effectively. Resources are allocated to CCGs.</p> <p>CCGs and NHS England are supported by commissioning support units (CSUs). Their role is to carry out:</p> <ul style="list-style-type: none"> • transformational commissioning functions, such as service redesign • transactional commissioning functions, such as market management, healthcare procurement, contract negotiation and monitoring, information analysis and risk stratification
PHE	Public Health England
PHOF	Public health outcome framework
PrEP	Pre-exposure prophylaxis is a course of HIV drugs taken before sex to reduce the risk of getting HIV
PHSE	Personal, health, social and economic education
SRH	Sexual and reproductive health
SRHH	Sexual and reproductive health and HIV
STI	Sexually transmitted infection
ToP	Termination of pregnancy/abortion

You're Welcome accreditation	The Department of Health's You're Welcome accreditation is a set of quality criteria for young people friendly health services. It provides a systematic framework to help commissioners and service providers to improve the suitability, accessibility, quality and safety of health services for young people.
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Appendix 1: Analysis of Survey

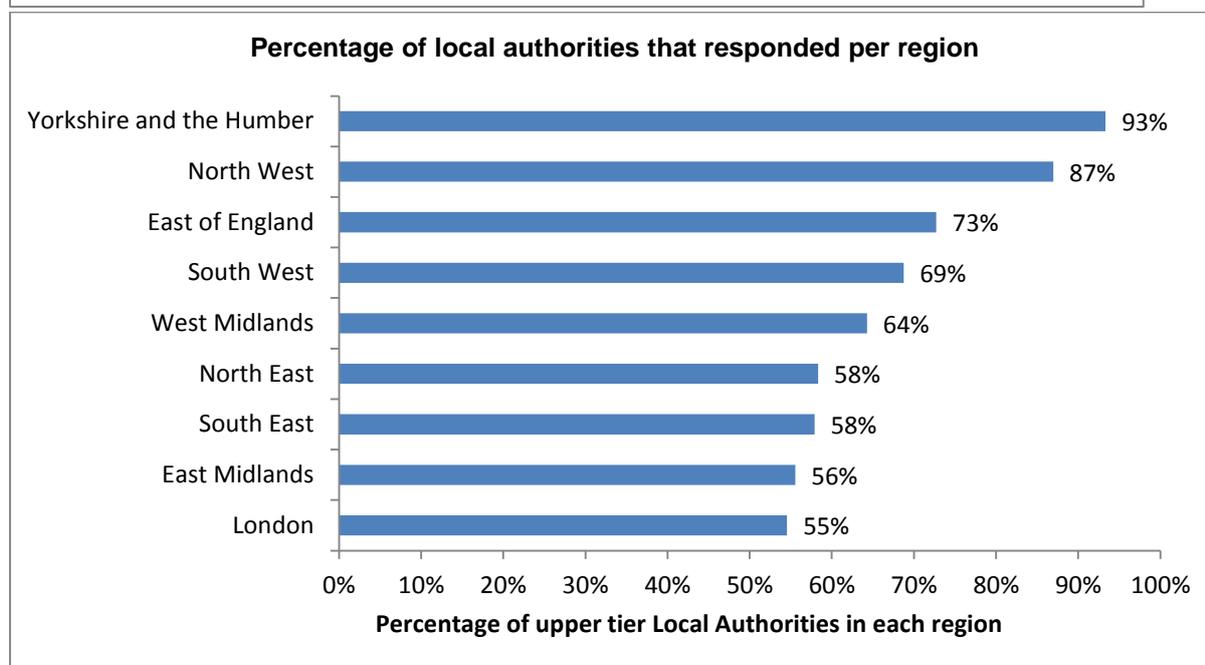
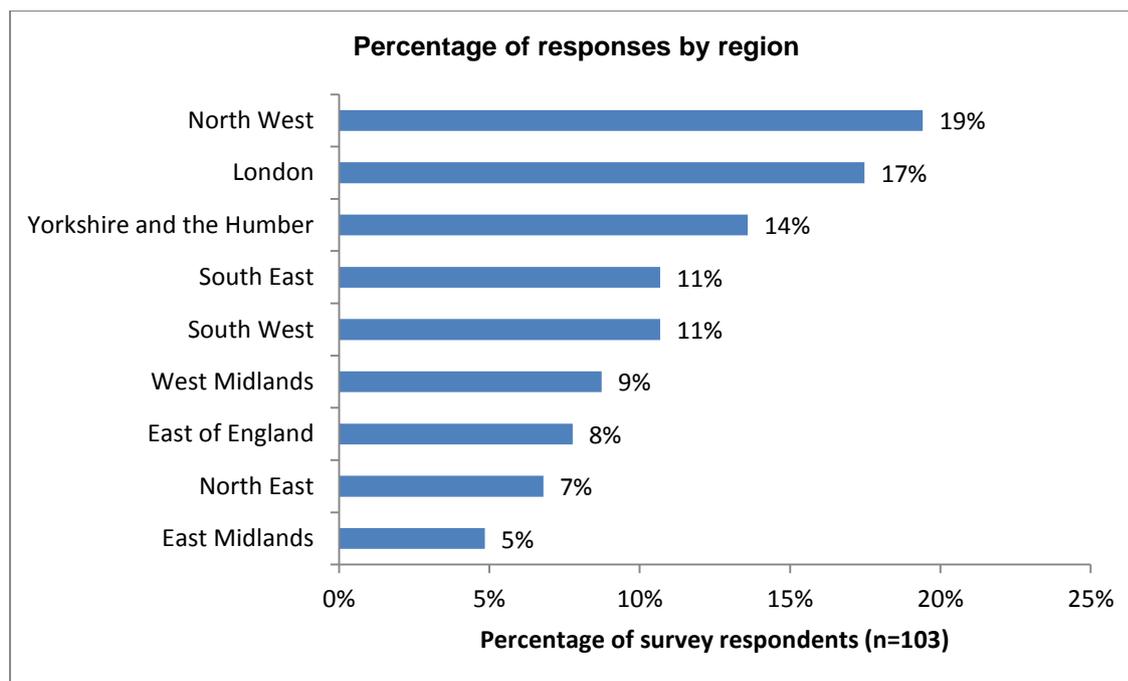
1.1 Local Authorities

1.1.1 Response rate

103 (68%) of the 152 upper tier local authorities (LAs) provided a response to the survey. The North West and London contributed the majority of responses (19%, 17% respectively), with the East Midlands contributing the least (5%). However, the actual local authority response rate per region ranged from 93% (14 out of 15) local authorities in Yorkshire and the Humber to 55% (18 out of 33) local authorities in London.

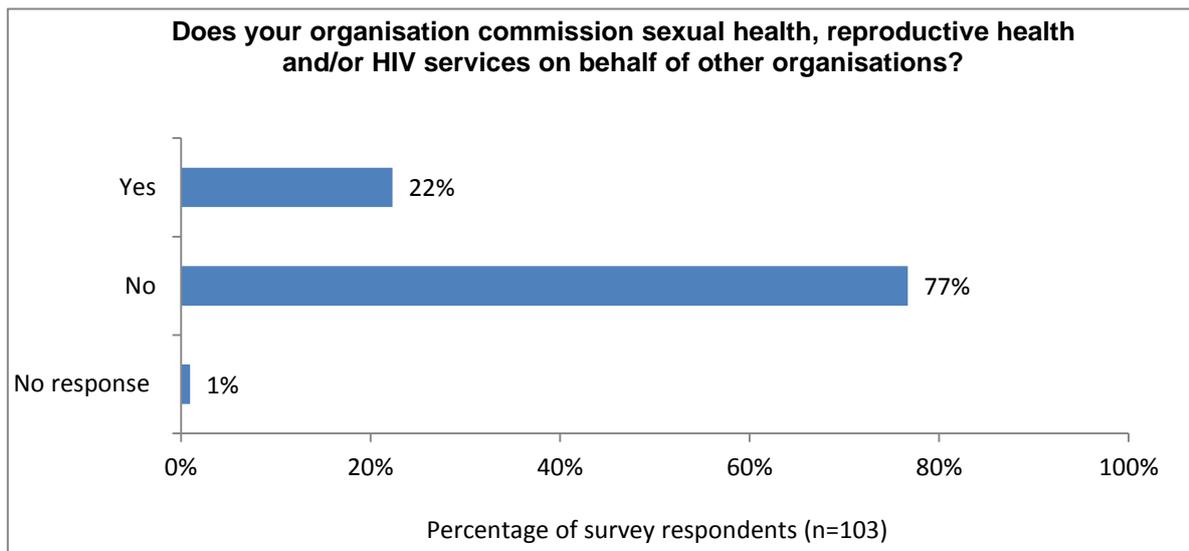
Table1: Survey responses by region and local authority response per region

Region	LA response to survey	% response by region	Total upper tier LAs in region	% LA response per region
North West	20	19%	23	87%
London	18	17%	33	55%
Yorkshire and the Humber	14	14%	15	93%
South West	11	11%	16	69%
South East	11	11%	19	58%
West Midlands	9	9%	14	64%
East of England	8	8%	11	73%
North East	7	7%	12	58%
East Midlands	5	5%	9	56%
Total	103	100%	152	68%



1.1.2 Commissioning support

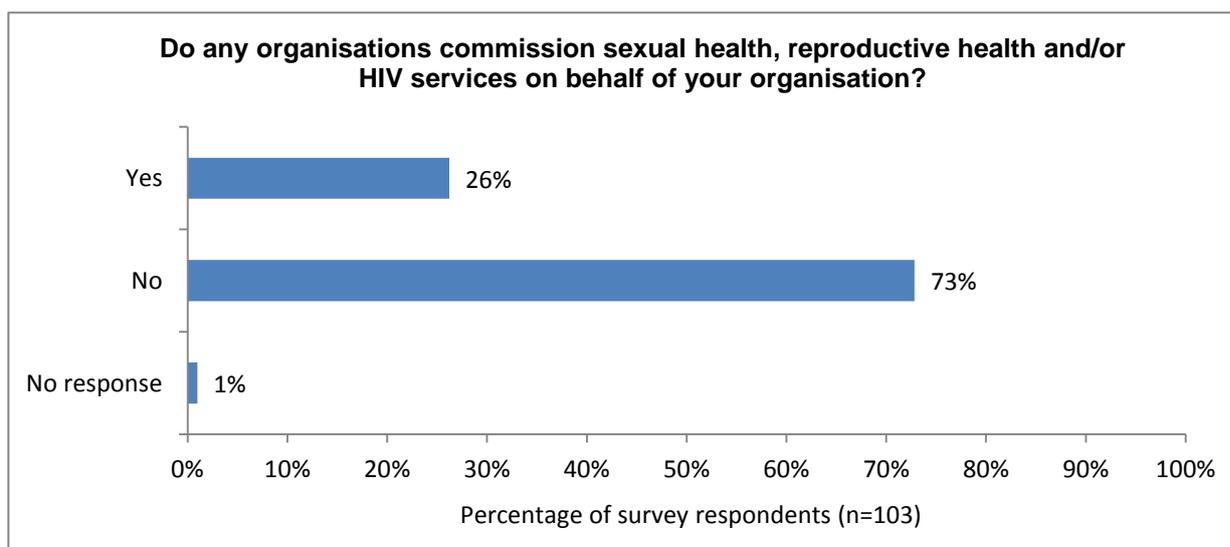
Question 4: Does your organisation commission sexual health, reproductive health and/or HIV services on behalf of other organisations?



Over a fifth of local authority respondents (22%) stated that they commissioned sexual health, reproductive health and/or HIV services on behalf of other organisations.

Where the response was 'Yes', respondents were able to enter further details. CCGs, other local authorities or NHS England were reported as having services commissioned by the local authorities. Although many responses did not state which services were commissioned: abortion, LARC and HIV prevention, treatment and care services were mentioned in a number of cases.

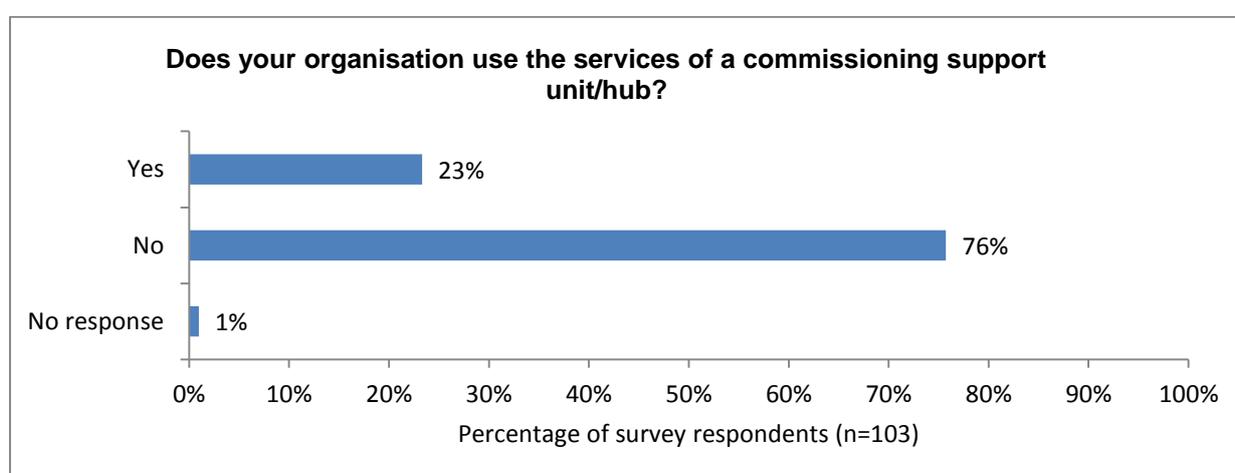
Question 5: Do any organisations commission sexual health, reproductive health and/or HIV services on behalf of your organisation?



Just over a quarter of local authority respondents (26%) stated that they had sexual health, reproductive health and/or HIV services commissioned on behalf of their organisation.

Where the response was 'Yes', respondents were able to enter further details. Organisations commissioning services on behalf of the local authorities included CCGs, NHS England, and other local authorities. Services included GUM services, HIV prevention, treatment and support services, STI screening and termination of pregnancies.

Question 6: Does your organisation use the services of a commissioning support unit/hub?

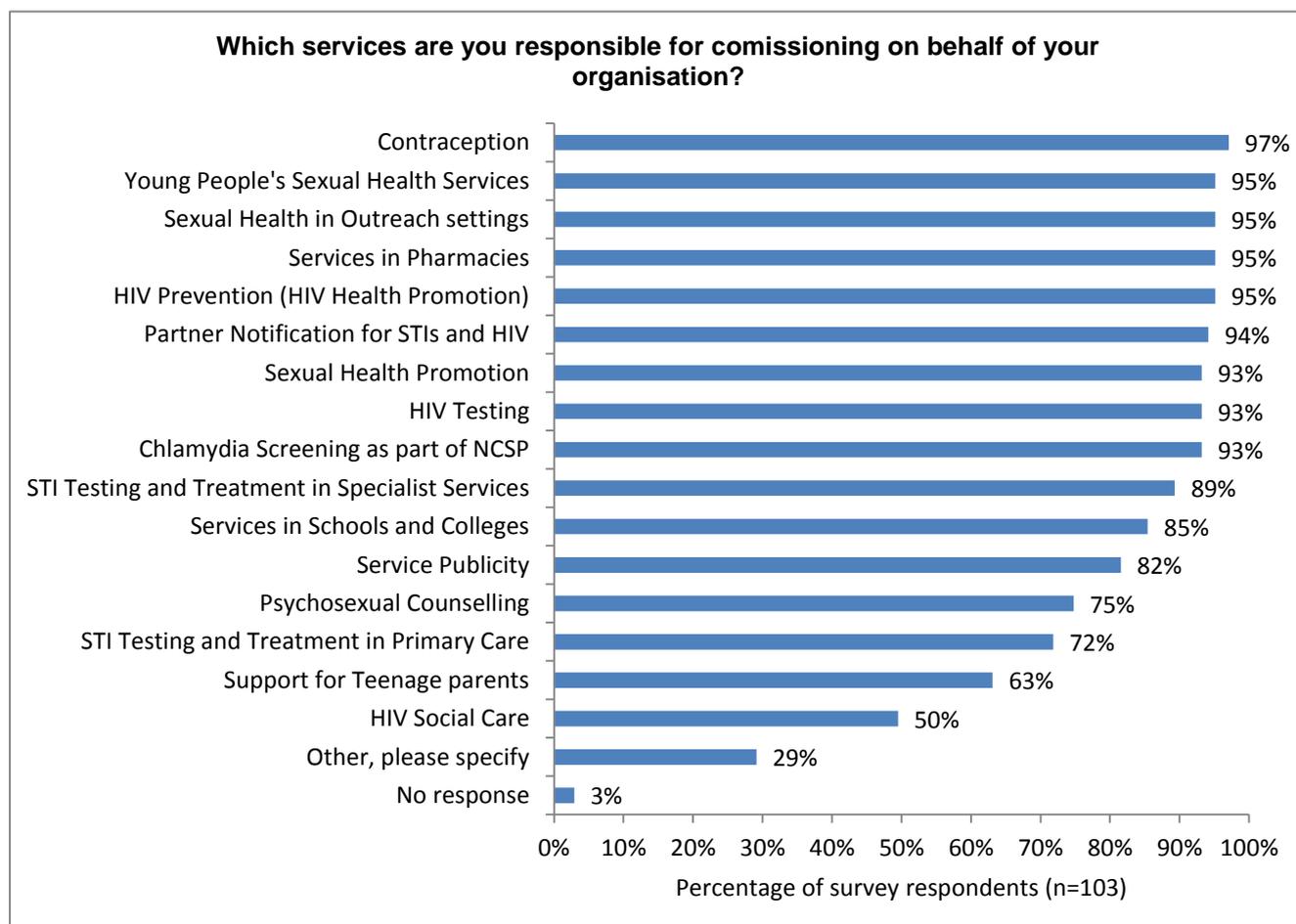


Over a fifth of local authority respondents (23%) stated that their organisation used a commissioning support unit or hub. The majority of 'Yes' responders provided further information around the use of a commissioning support unit or hub. Where this was used, it could be for medicines management support, data collection, GUM invoice or other activity validation, contract negotiation management or support with major procurements.

Most responders that stated 'No' did not provide further information. However, of those that did, respondents stated that they either had a specific commissioning team within public health, or they were exploring it as an option or internal commissioning and business support were already established.

1.1.3 Commissioned services

Question 7: Which service are you responsible for commissioning on behalf of your organisation?



Local authority respondents could select multiple responses for this question. The most common response was 'Contraception', with 97% of respondents stating that they had responsibility for commissioning contraception on behalf of their organisation. Only just under two thirds of respondents (63%) were responsible for commissioning 'Support for teenage parents' and only half (50%) were responsible for commissioning 'HIV social care'.

In the 'Other, please specify' category, respondents either clarified other entries or added distinct services such as:

- LARC in primary care
- HIV testing - home sampling; HIV Point of Care testing in pharmacy/ primary care
- online testing for some STIs
- opportunistic cervical screening
- work with sex workers
- services for men who have sex with men
- services for people with learning disabilities (including dedicated clinical services)
- a small programme for LGBTQI young people

- sex and relationship education in schools
- pregnancy options nurse including domiciliary
- a sex positive website that signposts young people to a range of sexual health services and provides sexual health promotion
- sexual health campaigns via providers
- C-care scheme (community and pharmacy based)
- pre & post termination counselling
- rape and sexual assault counselling service
- workforce development/training
- assurance programmes (eg mystery shopping)
- abortions and vasectomies on behalf of the CCG

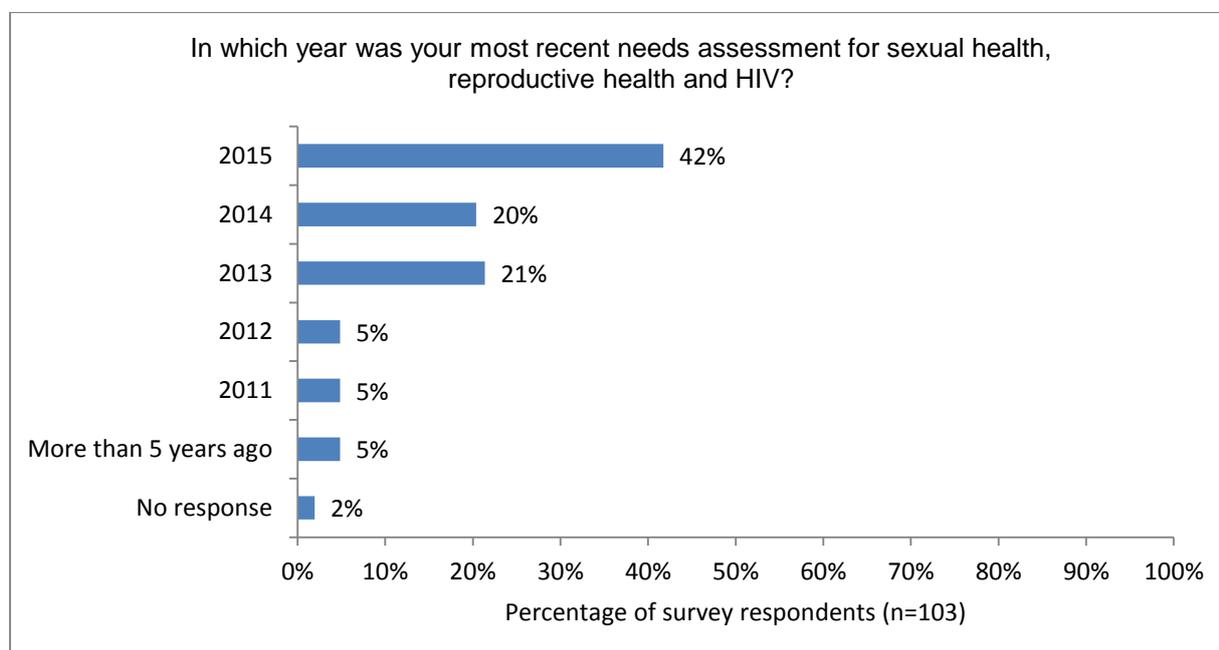
Two respondents noted the role of other directorates in the local authority regarding commissioning responsibilities:

“Support for teenage parents is only in relation to sexual health services. Wider teenage parents’ (TP) services are commissioned by LA Children's services.”

“A couple of items on the list are managed internally through other service areas eg support for teenage pregnancy delivered by CYP Directorate however these are funded through monies from PH budget. HIV Social Care sits within and funded by adult social care.”

1.1.4 Needs assessment and sub-populations

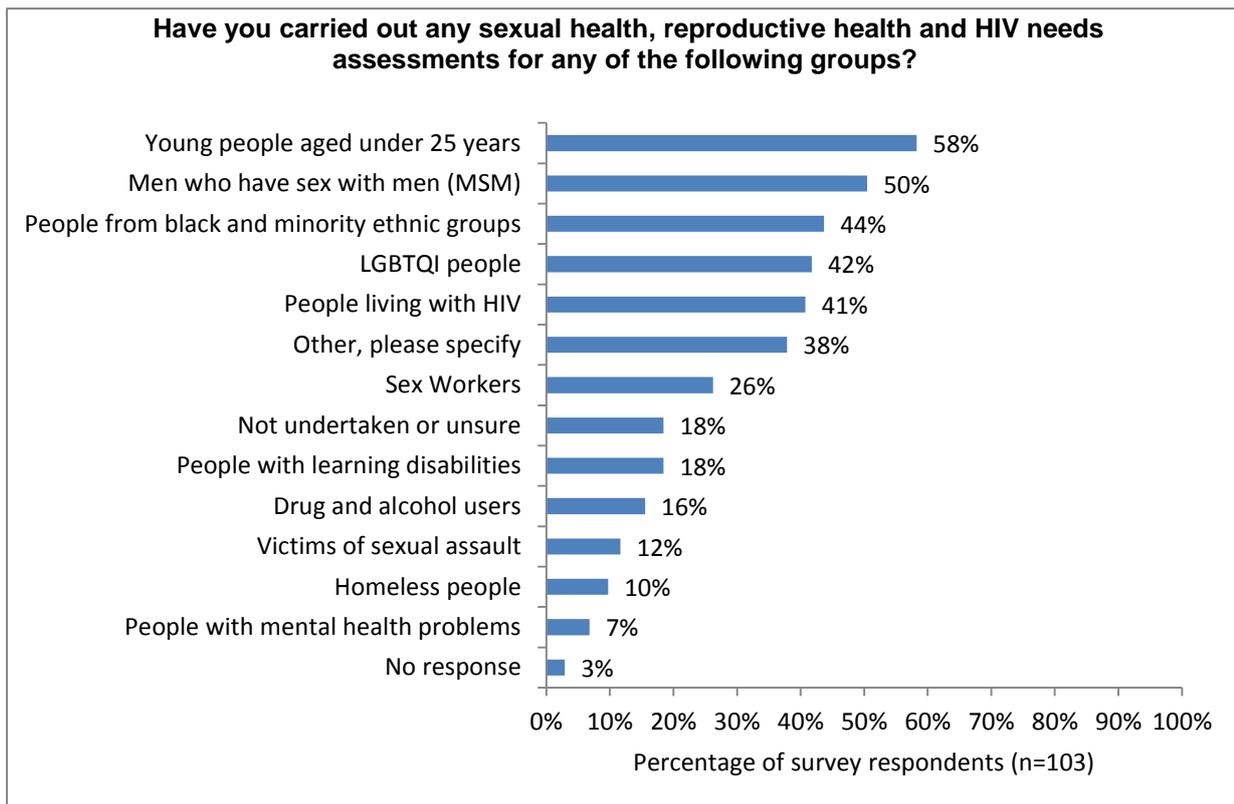
Question 8: In which year was your most recent needs assessment for sexual health, reproductive health and HIV?



42% of local authority respondents stated that they carried out a needs assessment in 2015. Over four fifths (83%) of respondents had carried out a needs assessment since 2013. 5% had carried out a needs assessment more than 5 years ago. Question 8 is also analysed later in relation to question 16 ‘When was the last time that your organisation tendered sexual health, reproductive health and/or HIV services’?

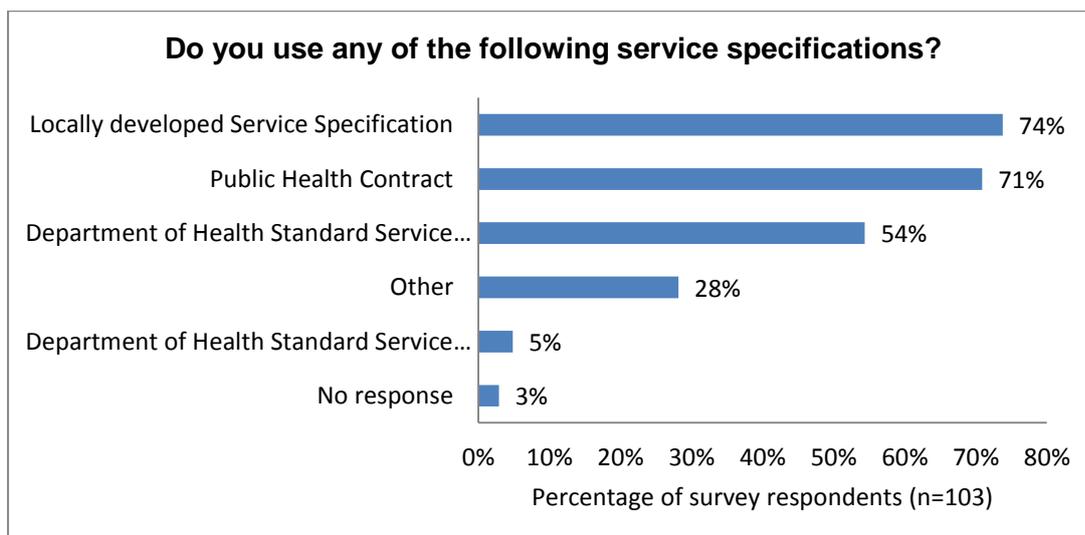
Question 9: Have you carried out any sexual health, reproductive health and HIV needs assessments for any of the following groups?

Local authority respondents could select multiple responses for this question. ‘Young people aged under 25 years’ was mentioned by 58% of the respondents. ‘People with mental health problems’ was the least common response (7%). Other groups specifically mentioned were migrant communities, over 50s’ sexual health and those in the armed forces.



1.1.5 Service specifications

Question 10: Do you use any of the following service specifications?



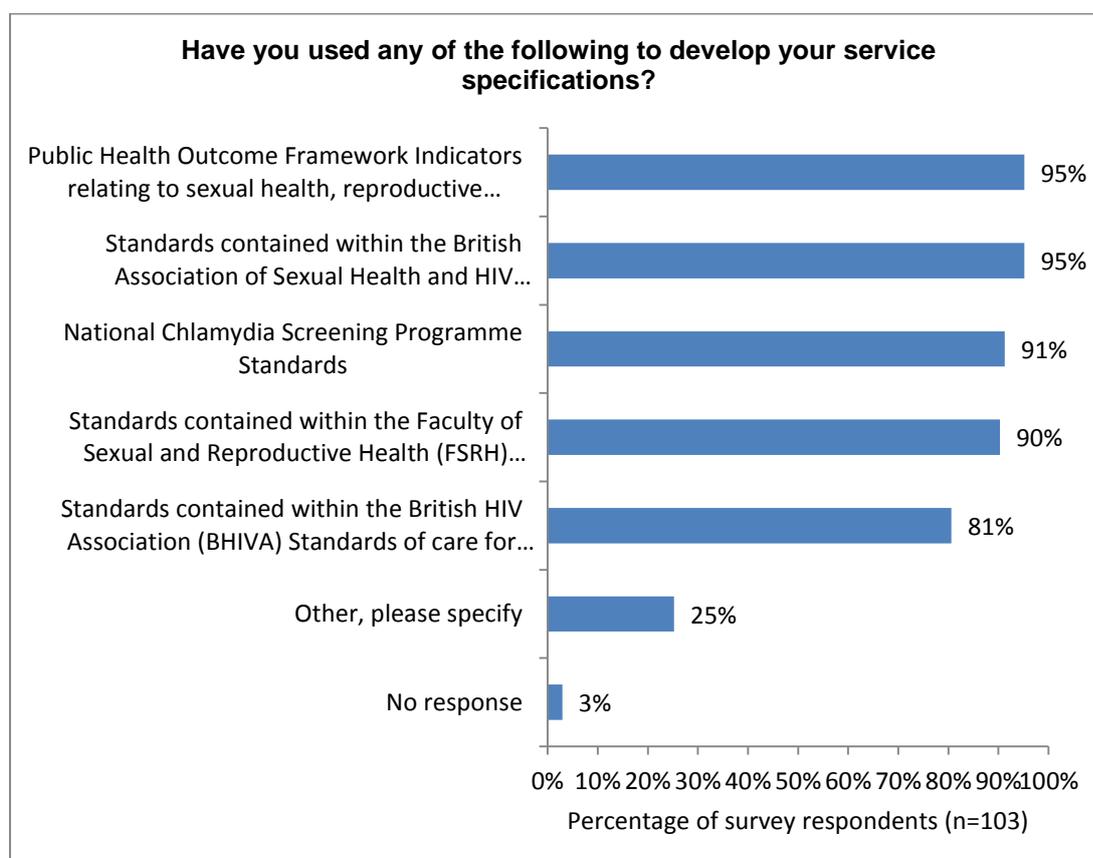
Local authority respondents could select multiple responses for this question. The most common response (74%) was that respondents used locally developed service specifications. This was followed closely by ‘Public health contract’ used by 71% of respondents.

The ‘Other’ response (filled in by 28% of respondents) provided the opportunity for further comment and this often clarified the responses that survey respondents had chosen. For example, a number of respondents selected ‘Locally developed Service Specification’ and ‘Public Health contract’ and stated that they had based their local specification on a specific service specification. The ‘Other’ response also included responses where the local authority was using a number of ‘inherited’ or locally developed specifications.

One respondent stated that they had built their specification based on examples of best practice through collaboration with neighbouring boroughs, and then reviewed it with a variety of relevant specialists. It was also cross referenced to the Department of Health’s clinical governance document.

The most common responses across all regions were a ‘Locally developed service specification’ and ‘Public health contract’. Use of the ‘Department of Health Standard Service Specification (Modified)’ was also common across all the regions.

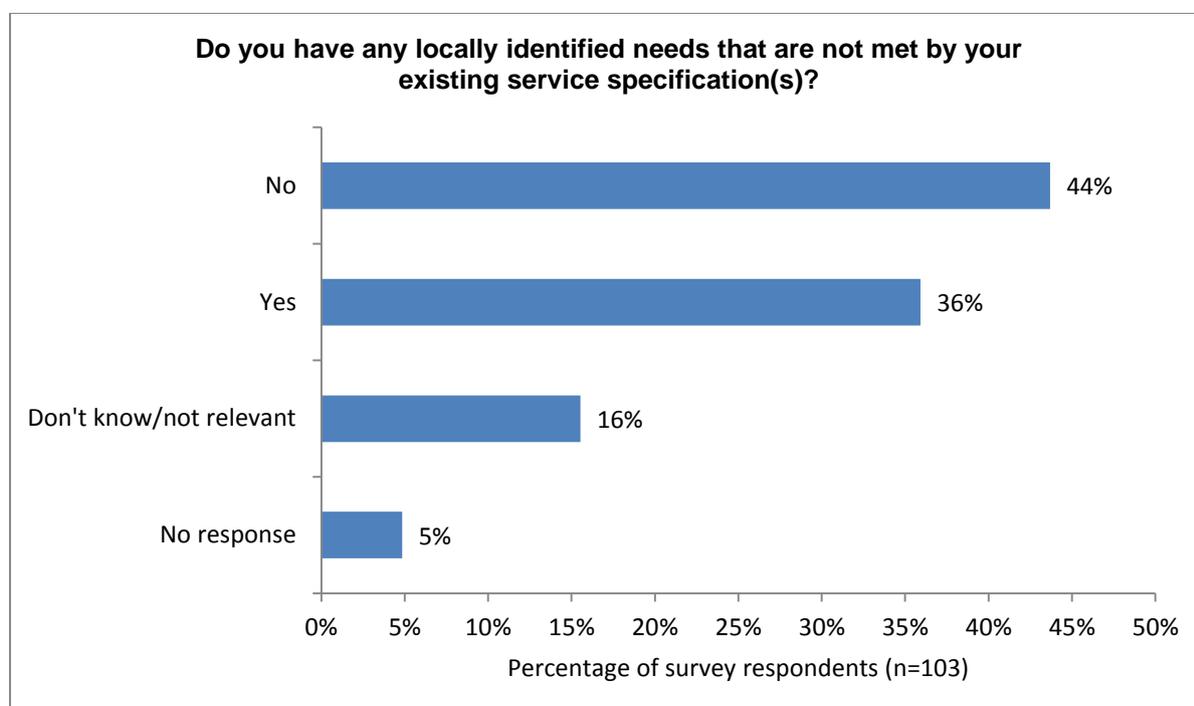
Question 11: Have you used any of the following to develop your service specifications?



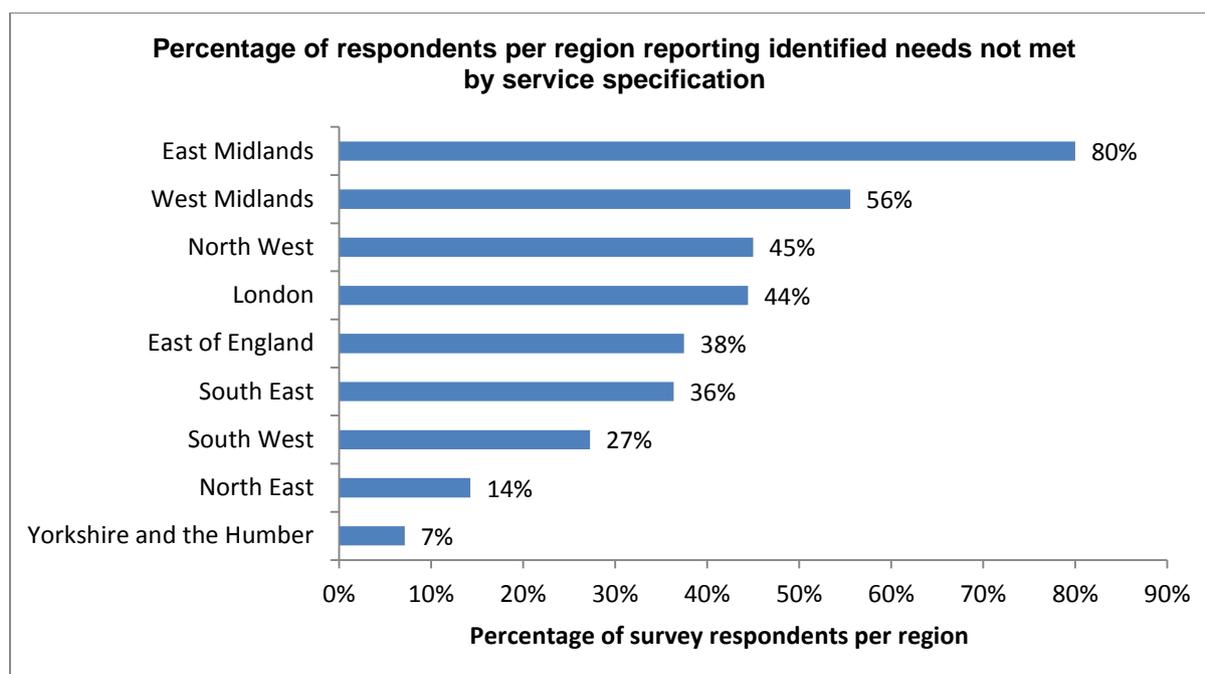
Local authority respondents could select multiple responses for this question. Both 'Standards contained within the British Association of Sexual Health and HIV (BASHH) Standards for the management of sexually transmitted infections document' and 'Public Health Outcome Framework Indicators relating to sexual health, reproductive health and/or HIV' were the most popular response, as 98 respondents (95%) indicated that they used both of these to develop their service specifications.

'Other' was completed in 25% of responses and included NICE standards/guidance, MEDFASH standards and Department of Health specifications, often in addition to specifications above.

Question 12: Do you have any locally identified needs that are not met by your existing service specification(s)?



44% of local authority respondents stated that they did not have any identified need that was not met by their existing service specification. However, over a third of respondents (36%) stated that they currently had identified unmet need in their local population. Unmet need ('Yes') was reported most by East Midlands respondents (80%, n=4 of 5) and least by Yorkshire and Humber respondents (7%, n=1 of 14).



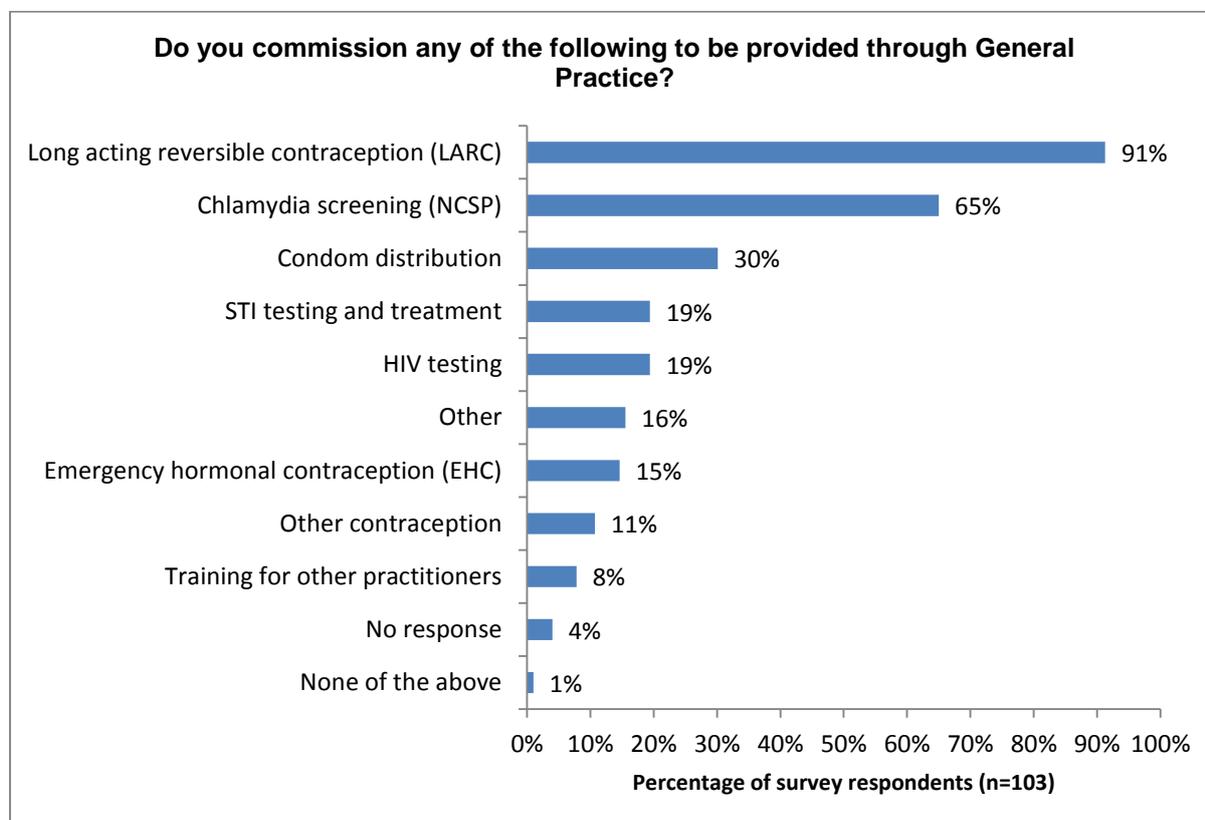
When the question was answered 'Yes', the most common response was that specifications would be reviewed and updated as needs are clarified. Specific needs that were identified by survey responders included:

- needs of **vulnerable young people**, for example young asylum seekers who require specific support and young people with overly sexualised behaviours were mentioned
- additional **outreach for higher risk groups** (such as MSM)
- needs of **sex workers** – particularly in males
- needs of those with **learning and physical disabilities**
- strengthening of **SRE provision** in schools
- needs of those with **mental health** issues
- greater involvement with **primary care providers** in provision of services

No detail as to what the identified needs were was provided in two responses. When the response to the question was 'No', the current service either met the identified needs or that improvements to the service had already been implemented. If the response provided was 'Don't know/not relevant' the responder was either unsure of the need or had been through a retendering process and needed to embed processes before identifying further need.

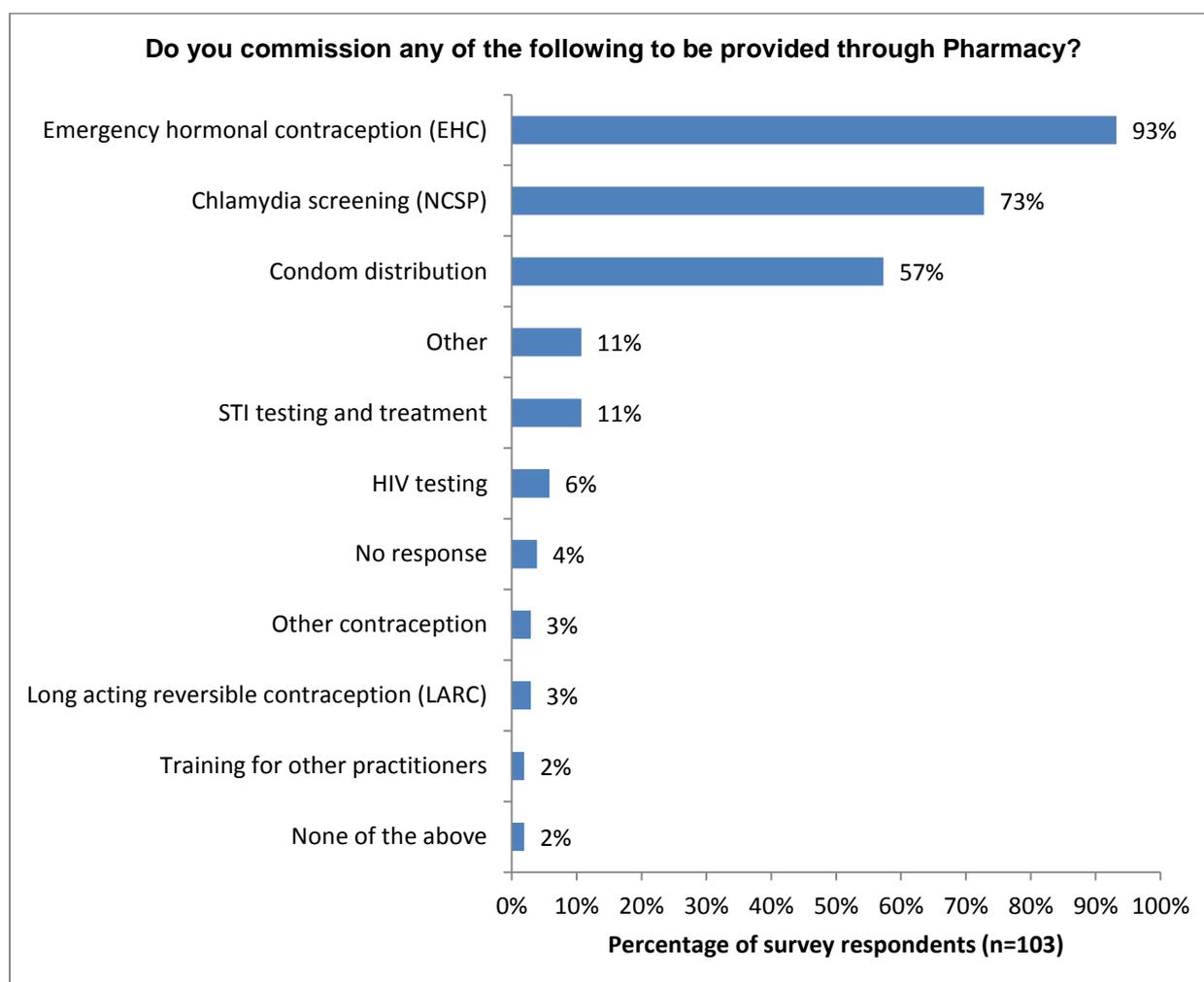
1.1.6 Access to services

Question 13: Do you commission any of the following to be provided through General Practice?



Local authority respondents could select multiple responses for this question. The majority of the local authorities commissioned ‘Long acting reversible contraception (LARC)’ and ‘Chlamydia screening (NCSP) through General Practice’ (91% and 65%, respectively). Nearly a third (30%) commissioned ‘Condom distribution’ and around a fifth (19%) commissioned ‘STI testing and treatment’ and ‘HIV testing’.

Question 14: Do you commission any of the following to be provided through Pharmacy?



Local authority respondents could select multiple responses for this question. ‘Emergency hormonal contraception (EHC)’, ‘Chlamydia screening (NCSP)’ and ‘Condom distribution’ were commissioned in pharmacies by the majority of respondents (93%, 73% and 57%, respectively). ‘STI testing and treatment’, ‘HIV testing’ and ‘LARC’ were commissioned by few local authorities through pharmacies. Chlamydia treatment and pregnancy testing were reported as specific services by 6% and 5% of respondents respectively (included as ‘Other’ in the figure above).

Question 15: Does your organisation have any concerns about current or future access to sexual health, reproductive health and/or HIV services provided in your area?

83% (86 out of the 103) local authorities provided a response to this question. It is important to note that not all local authority identified concerns. There were 17 blank responses and 8 respondents explicitly stated that they had no concerns.

Where concerns were identified, responses fall into five broad themes: ‘financial concerns’, ‘commissioning process concerns’, ‘structural concerns’, ‘workforce concerns’ and ‘supply-demand concerns’.

Financial concerns

The cut in the public health grant was a recurring concern for local authorities. In addition to the in-year cut, local authorities were concerned about requirements for ongoing savings. Going forward, maintaining current levels of service provision was not felt to be possible. The potential impact of this was complex. By reducing access to specialist services they hoped to redirect those requiring less specialist (and costly) care to pharmacies and primary care. However, reduced capacity in general practice meant that there was a lack of confidence that the provision of services commissioned through GPs would actually be provided (LARC and contraception in particular). Service users would then be redirected to specialist services thereby increasing demand rather than reducing it. Example comments include:

“There are concerns regarding the Department of Health cuts to the Public Health grant which may seriously impact on front line delivery going forward.”

“Future cuts to the Public Health Grant could have an adverse impact on sexual and reproductive services. Further pressure on GPs could lead to an adverse impact on contraceptive services and on access to cervical screening within the primary care setting.”

“The impact of reductions to the Public Health Grant will place further pressure on the sexual health services; the extent to which additional savings will be met from primary care or specialist settings will depend on the size of future grant allocations. There are concerns about any future required savings since significant savings have already been committed; additional reductions in budget will likely lead to reduced access for some parts of the population, based on needs.”

Payment mechanisms were not felt to be fit for purpose. The variety and non-standardised approach to payment was felt by some to be unsustainable. This fragmented approach led to inefficiencies and wastage.

If services located in one local authority were the closest option for large populations resident in neighbouring local authorities then footfall from ‘out of area’ residents had a large impact on capacity. This also had an impact on finance as the cross charging mechanisms were timely and complex.

“A fixed budget with an open access service (GUM/CASH) is highly problematic as usage increases. The administration behind cross charging arrangements is time consuming and a drain on council limited resources.”

Commissioning process concerns

The ‘complicated’, ‘complex’ and ‘fragmented’ commissioning arrangements for sexual health, reproductive health and HIV was a particular concern for impact on access. Commissioning sometimes happened in silos and without adequate communication between responsible bodies or clear responsibilities. This led to duplication of effort. Fragmented commissioning led to fragmented pathways which led to concerns about access.

“The split commissioning of Sexual Health Services across local authority, CCG and NHSE has meant that seamless pathways and well established partnership working have been challenged tremendously in order to sustain and develop service provision.”

“Silo working has reflected the division of commissioning responsibilities and we must work hard with CCG, NHSE, PHE and councils to have a sensible systematic approach.”

“The current commissioning arrangements for sexual health services nationally are complicated, complex and inadequate to achieve a truly efficient and joined up system. CCGs commissioning termination services, NHSE commissioning HIV treatment, central commissioning of GPs to deliver cervical screening and local authorities commissioning other aspects of sexual health services and preventative work causes duplication of work, and does not help to align local commissioning procedures and funding streams. Whilst we are working to address this, a more simplified ownership of the budgets would make commissioning much more straightforward - we would suggest sexual health should move to Integrated Care systems and the budgets for all aspects (including HIV treatment which... is too common to be called specialised commissioning) and social care services would make more sense both from a commissioning perspective and from a provider perspective - making truly integrated services easier to achieve.”

Structural concerns

The rurality of some local authorities made transport and access to physical services challenging for some populations.

“Rurality in our area means that access to services can be challenging.”

“New non-NHS providers could find it difficult to secure appropriate healthcare premises in which to see patients.”

“The pressure on NHS to use their premises for other health services resulting in sexual health providers having to find alternative and appropriate (clinical) premises, which are in short supply.”

Workforce concerns

A number of concerns were raised about the clinical workforce, both in specialist and non-specialist settings:

- vacancies and unfilled posts in GUM, SRH and GP
- knowledge and training of staff to provide LARC
- enthusiasm of staff to provide commissioned services (particularly GP and LARC)
- a reluctance of provider workforces to embrace fundamental changes to service provision

“Lack of trained professionals to provide sexual health services. Therefore vacancies in sexual health services, reduction in clinics, limited LARC provision.”

“A number of concerns have been raised regarding LARC training and revalidation due to GPs being asked to gain FSRH Letters of Competence (from local accreditation).”

“Capacity in GP practice and community pharmacy is at saturation point. It is becoming increasingly more difficult to maintain enthusiasm for providing services. GPs are also reluctant to maintain Letters of Competency and registration to appropriate learning organisations.”

“... reluctance of current providers to fundamentally change practice across organisational boundaries.”

The burden of data collection, analysis and interpretation on providers was also felt to have a negative impact on capacity.

“... providers... are frustrated re. the burden of data collection and how this results in meaningful information.”

Supply-demand concerns

Generally there was felt to be a decrease in capacity across the healthcare system (primary care and specialist settings). This was a result of complex interactions between funding, commissioning, workforce etc.

“Primary care providers are requiring increasing levels of payment which without corresponding levels of income through the Public Health Grant are unaffordable.”

There was a desire to use available capacity for those at greatest risk of ill health. However, current capacity was taken up with:

- low risk/worried well
- non-residents (out of area)
- those unable to see their GP
- those that the GP was unwilling to see (referring to specialist services despite being commissioned to provide services)

“We need to consider the use of home sampling technologies in order to reduce the 'worried well' accessing mainstream services whilst ensuring they have accessible services. This will have cost implications both for the local authority and our specialist provider.”

There was a concern that demand was likely to rise further with:

- impact of Chemsex on STI epidemiology
- PrEP monitoring and provision
- HPV vaccination for men

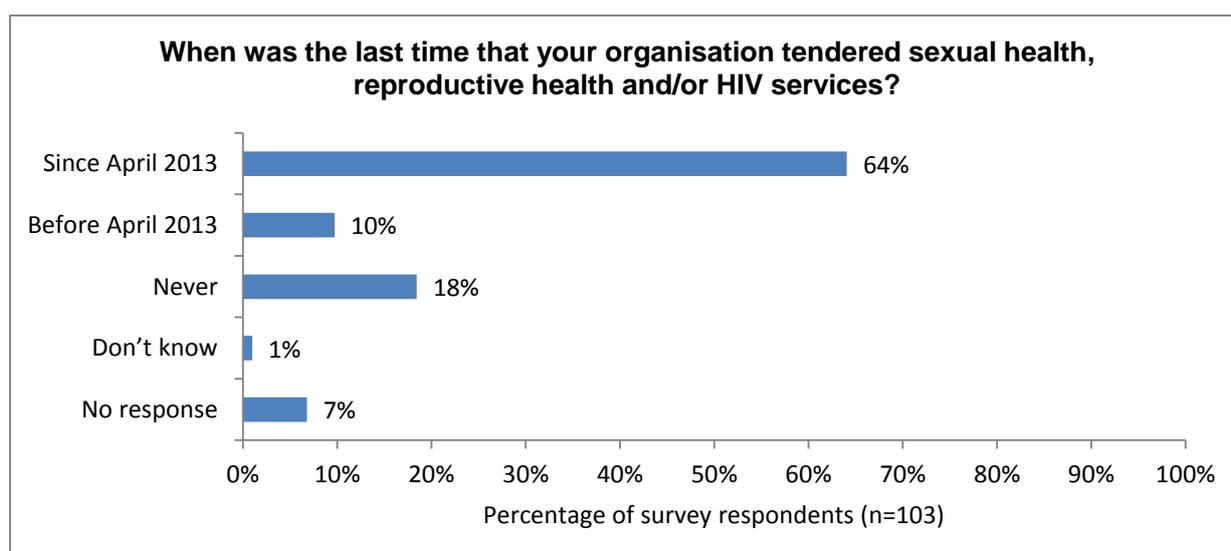
“There are new work areas which will impact on current service capacity - for example PrEP and HPV vaccination for at risk men.”

Several local authorities expressed a general concern that:

- health inequalities may worsen
- LARC and cervical cytology would fall by the wayside along with any focus on prevention
- if risks were not managed then organisations would suffer reputational damage
- current model is unsustainable

1.1.7 Tendering

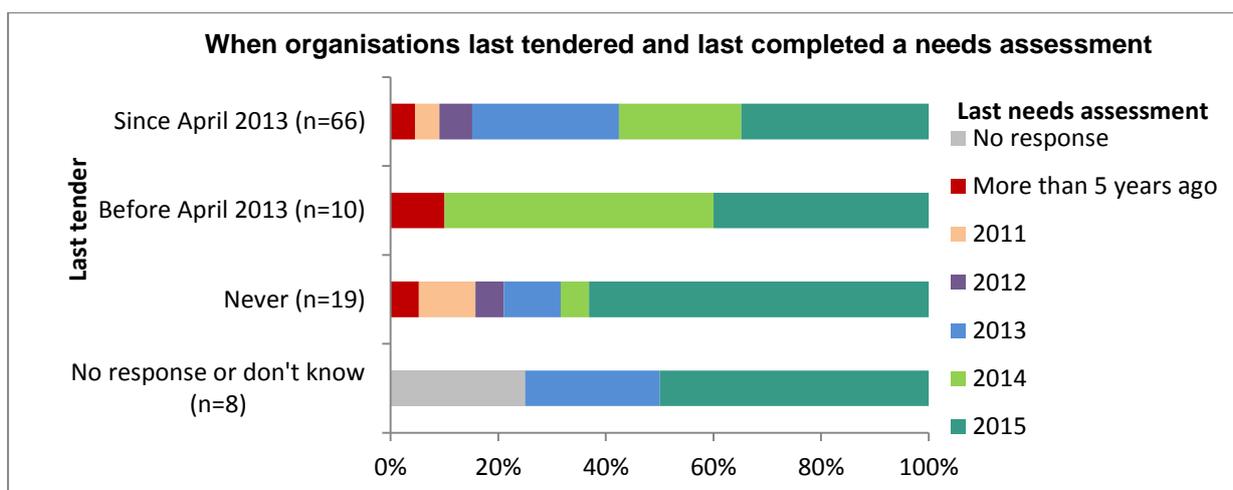
Question 16: When was the last time that your organisation tendered sexual health, reproductive health and/or HIV services?



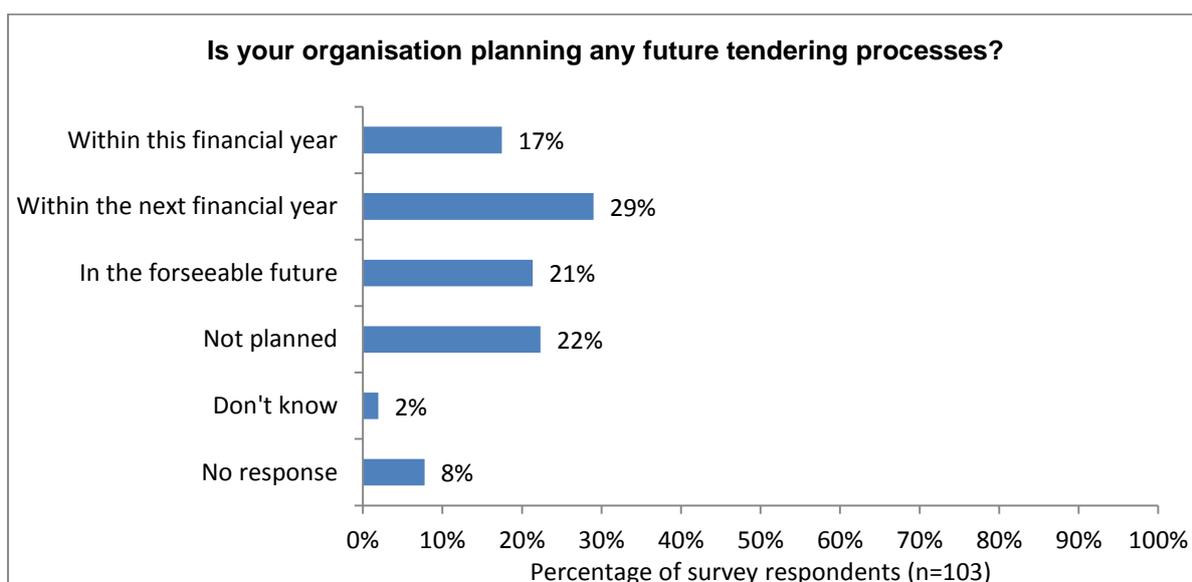
Nearly two thirds of local authority respondents (64%) reported that their organisation had undertaken a tender since April 2013. Nearly a fifth (18%) reported that the organisation had never tendered services. In the 'Further Information'

section, respondents provided some more detail about the tendering process, including specific dates.

The following chart compares responses to this question with question 8 ('In which year was your most recent needs assessment for sexual health, reproductive health and HIV?'). Where the last tender took place after April 2013, almost all (95%) respondents reported that needs assessments had been undertaken between 2011 and 2015, with 85% undertaken in 2013 (n=18), 2014 (n=15) or 2015 (n=23). Of all 86 respondents who reported needs assessments between 2013 and 2015, 65% had tendered since April 2013.



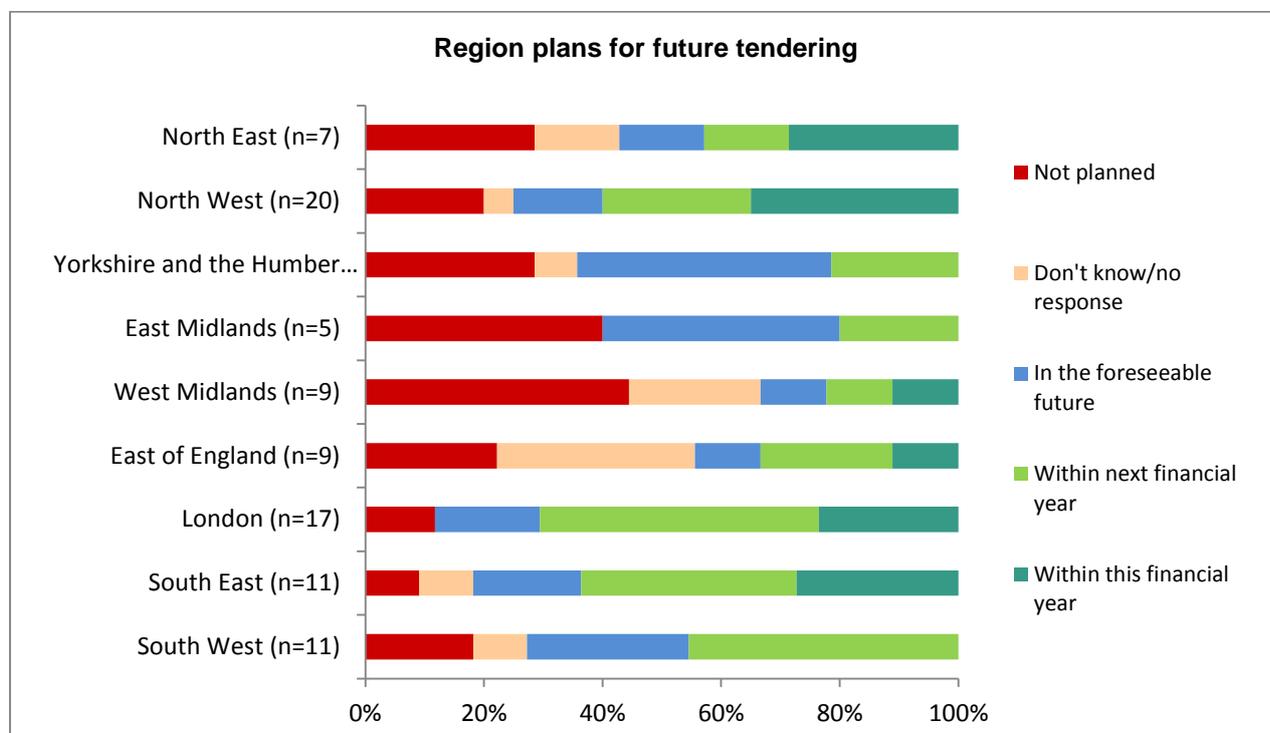
Question 17: Is your organisation planning any future tendering process?



17% of local authority respondents reported that their organisation was planning a tendering process within this financial year and 29% were planning to tender within

the next financial year. In total, just over two thirds (67%) were planning future tendering processes.

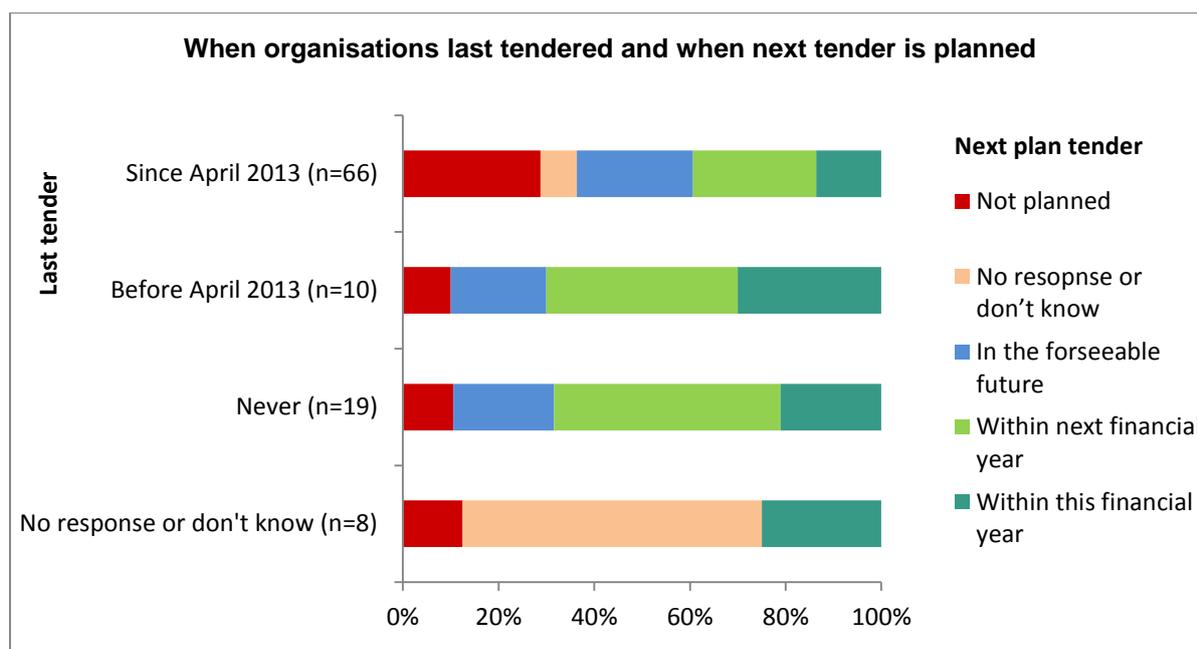
A regional breakdown of the 95 responses provided is displayed below.



London and the South East had the largest percentage of respondents (90%, 80% respectively) who reported that they had plans for future tendering. The West Midlands had the largest percentage of respondents (44%) with no plans for future tendering.

Where tendering processes were planned for the next financial year, respondents reported that these were out to tender, or completing a needs assessment for the tender. Where responses were 'In the foreseeable future', respondents were often working from current contract end dates. Where future tendering processes were not planned, respondents stated that services had often just been retendered.

The following chart shows the comparison between the responses to this question and the previous question regarding when last tendered:



Of the 19 respondents indicating that they had never tendered services, over two thirds of the respondents (68%) were planning a tender within this or the next financial year. Of the 66 who had tendered since April 2013, over a quarter (29%) were not planning a further tender.

Question 18: Please describe any issues around commissioning across patient care pathways with commissioners or other parts of the system.

89% (92 out of the 103) local authorities provided a response to this question, and some entries were quite extensive.

Various issues were highlighted and these are grouped into 3 main themes:

Lack of engagement and disrupted patient pathways

Many respondents highlighted the need for greater joined up commissioning regarding HIV treatment and care, abortion services, GP LARC prescribing, cervical smears and/or psychosexual services. Some also highlighted this issue in relation to HIV testing, SARC services, prison/offender health, substance misuse, maternity services, community gynaecology, genital dermatology, vasectomies and/or chlamydia screening in over 25s.

However, many noted that they had had problems engaging with other commissioners and several highlighted the resulting impact on patient pathways, for example:

Lack of engagement

Some respondents noted what appears to be resistance from other commissioners:

“Despite extensive efforts to collaborate around tenders met resistance in partners.”

“NHSE [*named*] has been very reluctant to either share data or information or engage meaningfully”

Some respondents also highlighted a lack of consultation and timely communications from other commissioners regarding their plans and changes to specifications, for example:

“The commissioner for terminations of pregnancy (TOP) services and vasectomy, based at [*named*] Clinical Commissioning Group, has commissioned services without consultation with the sexual health commissioners at [*named*] LA.”

“SARC/HIV- communication from NHS England could be better surrounding these elements. eg timely communication from NHSE surrounding intentions and progress.”

Disrupted patient pathways

Respondents provided examples of actual or potential disrupted patient pathways arising from a lack of engagement between commissioners such as:

“Menorrhagia, cervical screening, genital dermatology and TOP pathways have all been disrupted by split commissioning pathways.”

“Although we are tendering an integrated SH service, ironically we are having to exclude some service elements in the tender due to fragmentation of funding & commissioning responsibilities, eg sexual dysfunction, patient choice for cervical screening (out of GP practices), some SH professional training (eg cervical smear takers), community gynae and psychosexual health counselling.”

“Cervical screening being commissioned by NHSE with no resource for local councils to commission this from local sexual health clinics has removed choice for patients and possibly has meant women have not accessed their smear tests.”

“NHSE when commissioning the Sexual Assault Referral Centre did not consult with sexual health commissioners when they removed elements of care from their service specification, affecting both pathways [and] local service delivery.”

Challenges arising from a lack of clarity and differing priorities and pressures

Many respondents highlighted underlying challenges for joined up commissioning relating to a lack of clarity and differing priorities and pressures.

Lack of clarity

Many highlighted a lack of clarity and different views regarding who should be responsible for commissioning elements of specific services and/or a lack of supporting data.

Many highlighted the issue of long-acting reversible contraception (LARC) prescribed for menorrhagia/heavy menstrual bleeding (HMB) in GP settings, for example:

“Ongoing efforts to clarify GMS/PMS contract baselines for contraception in order to budget for IUD provision.”

“Complications in differentiating HMB/Contraception with regards to Identifying, monitoring and responsibility for payment.”

Other areas highlighted where there was a lack of clarity and/or different views included HIV services, abortion services, maternity services, cervical screening, psychosexual services, and/or other GP services, for example:

“STI testing in HIV services (who pays)”

“We have encountered challenges in relation to determining where the commissioning responsibility sits for contraception as part of the maternity and TOP pathways”

“Struggled to engage with NHS England around the specific issue of cervical screening and what they see as their responsibility”

“Complications in differentiating sexual health elements of psychosexual health - No national guidance to support commissioners”

“There is a lack of clarity of what level of sexual health services should be provided in primary care within the GP contract, particularly for STI testing & treatment”.

Different priorities and pressures

Many also highlighted that problems engaging with CCG and NHS England partners were due to differences in priorities, and pressures arising from: a lack of capacity or

expertise; different funding streams and timescales; complications due to the number of organisations involved; costs saving not being passed on; and/or greater pressures on local authorities to make changes to commissioned services and deal with budget cuts and cross-charging. For example:

Sexual health is not the priority of partners

“There is often difficulty in engaging NHS and CCG partners in conversations due the small amount of sexual health service provision they commission”

“It is difficult to align commissioning cycles and intentions with other health organisations with differing priorities and responsibilities.”

Lack of capacity or expertise

‘It can be difficult to secure time to meet with the regional specialist commissioner due to their workload demands’.

‘People new to sexual health with limited understanding of connections and systemic approach needed.’

Different funding streams and timescales

“Difficulties matching time lines and length of commitment for various aspects very challenging.”

“HIV Treatment and Care, and Cervical Screening are being commissioned separately by NHSE. Integrating these into a single sexual health service has not been possible as part of the current tender due to different funding streams and commissioning timetables.”

Complications due to the number of organisations involved

“We have [a number of] CCGs in the LA area making agreement across patient care pathways challenging.”

“It is challenging to co-ordinate due to the number of commissioning organisations involved and the levels of financial challenge in all those organisations.”

Costs saving not being passed on

“There are some tensions around funding, with added investment in LARC and STI provision by local authority resulting in cost savings to NHSE (eg with

reduced need for oral contraception under the GP contract) and the CCG (with lower costs for abortion, infertility, PID services, etc.). However, there is no investment from these organisations (beyond that required in abortion services) and no commitment at present to reinvest some of the savings back into sexual and reproductive health promotion.”

“The current commissioning arrangements between the LA, CCG and NHSE make expanding HIV testing challenging. The costs saving by earlier diagnosis are not reaped by the organisation who invests in testing.”

Greater pressures on local authorities to make changes to commissioned services and deal with budget cuts and cross-charging

“Different rules re. procurement has meant that local authorities have had to consider tendering for services; this has not been a pressure for the other commissioning organisations. Local authorities have also had to reduce budgets - again, this pressure has not been as severe for the other commissioning organisations.”

“There are financial risks and avoidable administration incurred by cross charging (out of area payments).”

Examples of collaboration

However, many respondents also provided examples of collaborative working despite the challenges. These included:

Local authorities working with their CCG(s) regarding abortion services

There are examples of local authorities working with their CCG(s) in various ways to ensure appropriate STI testing and contraception support in abortion settings and/or timely access to abortions:

“We worked with the CCG on their recommissioning of TOP services to ensure appropriate STI testing was available and referral for contraception support takes place”

“*[named]* LAs commission on behalf of their CCGs via Integrated Commissioning Services”

“We monitor access to termination services and audit reasons for delayed access on behalf of the CCG”.

Local authorities working with their NHS England partner regarding HIV treatment and care

There are examples of local authorities working with NHSE to align HIV treatment and care pathways:

“It is essential for SH services to be commissioned alongside HIV treatment and care services as we have - this was a very positive experience for PH and NHSE”

“We reached a collaborative commissioning agreement with NHS England to include HIV treatment in our procurement process”.

Multiple and/or whole system commissioning

There are also examples of local authorities working with multiple commissioners to align patient pathways:

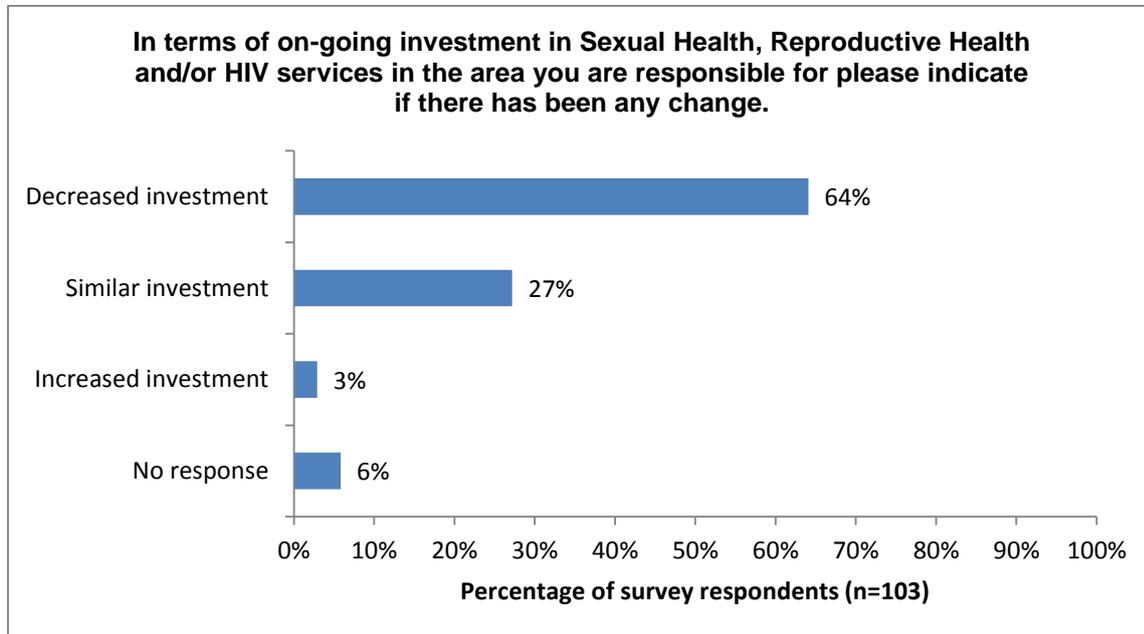
“We have entered into a collaborative commissioning arrangement with 3 other LAs, 2 CCGs and NHSE. This approach helps to ensure a mechanism for aligning pathways for core elements of service provision.”

“Commissioners across *[named area]* have worked together to divide responsibilities, with people leading on different areas and working together to maximise impact and capacity.”

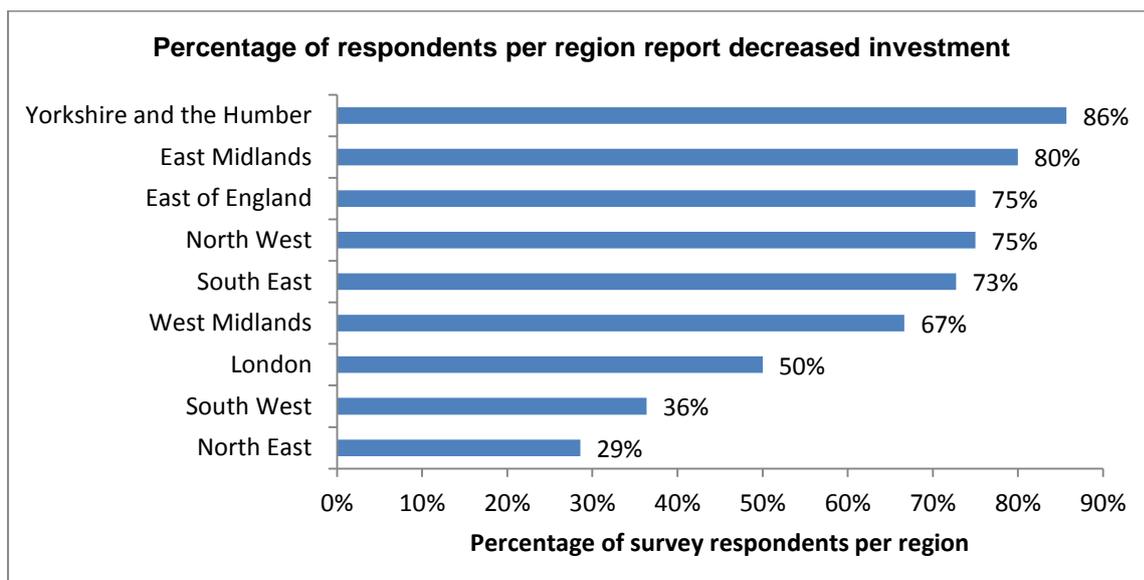
“Won the FPA Brook SH award for best practice in whole system commissioning.”

1.1.8 Re-tendering and changes to investment

Question 19: In terms of on-going investment in sexual health, reproductive health and/or HIV services in the area you are responsible for please indicate if there has been any change.

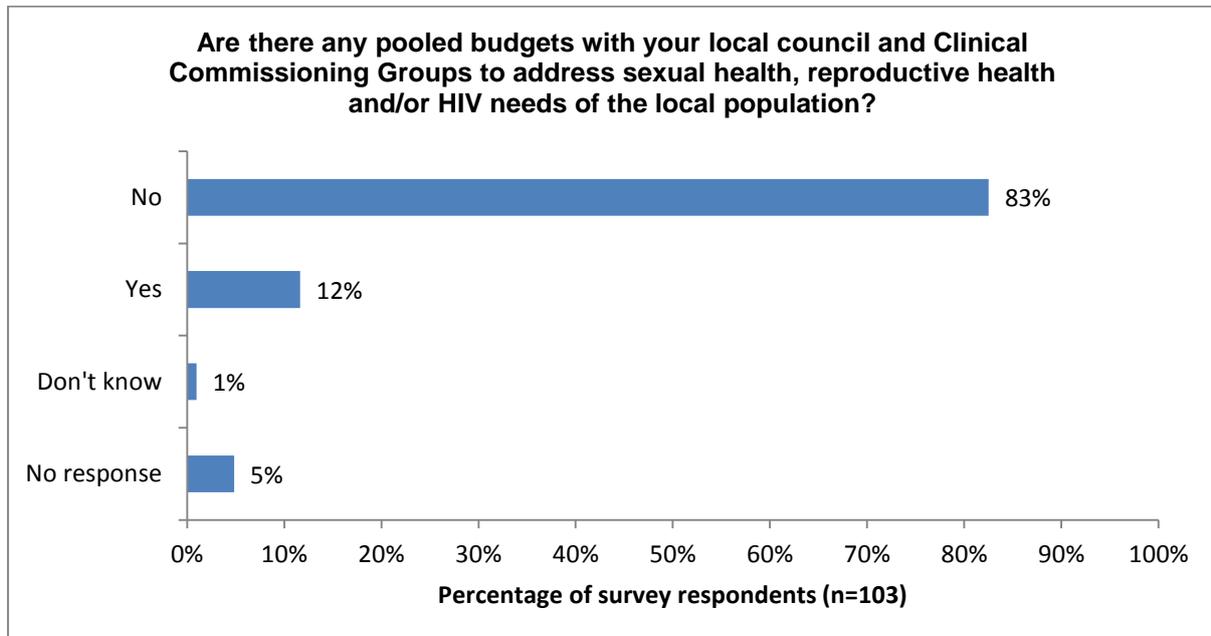


Nearly two thirds (64%) of local authority respondents reported a decreased investment in sexual health, reproductive health and/or HIV services for which they were responsible. 30% reported similar or increased investment. Decreased investment was reported most by Yorkshire and Humber respondents (86%, n=12 of 14) and least by North East respondents (29%, n=2 of 7).



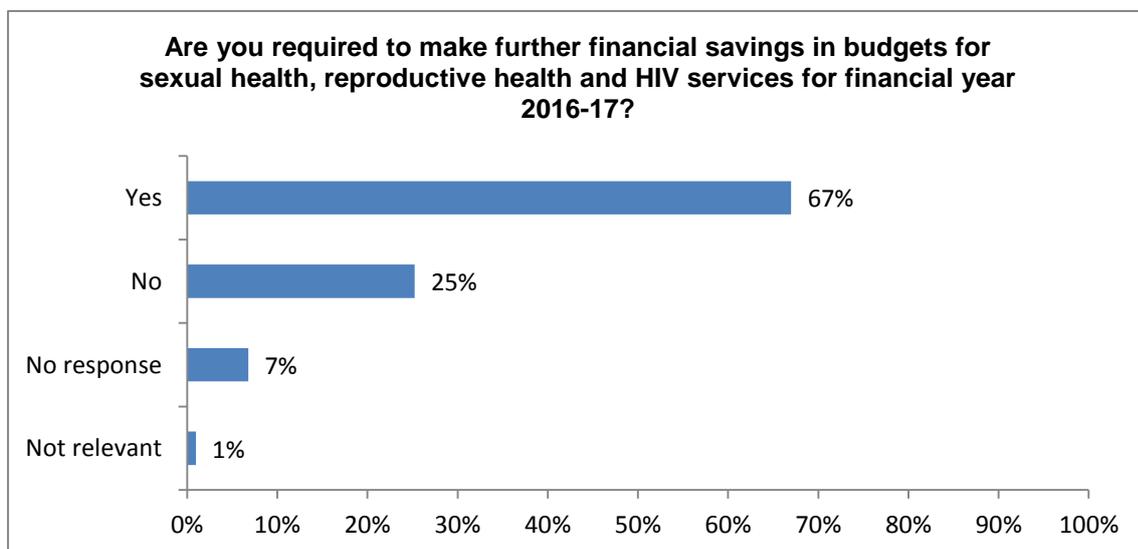
11 of the 66 respondents who reported decreased investment provided an indication of the degree of change. This ranged from 5% to 25% disinvestment, with a mean average of 14% disinvestment.

Question 20: Are there any pooled budgets with your local council and Clinical Commissioning Groups to address sexual health, reproductive health and/or HIV needs of the local population?

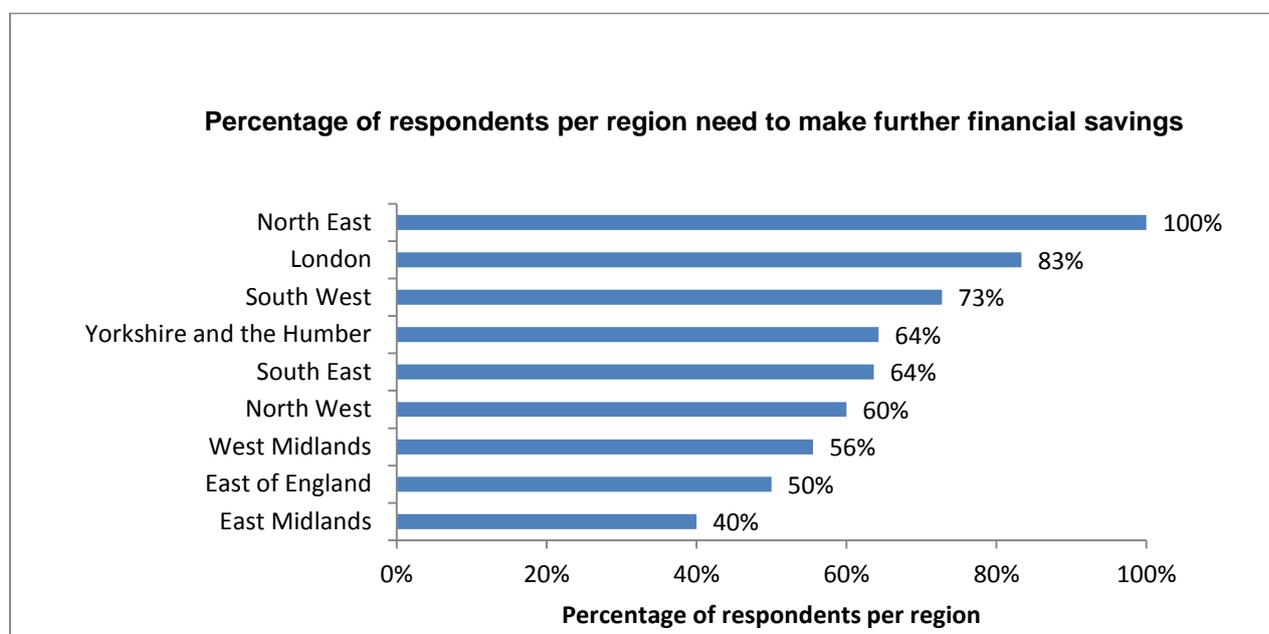


The majority of respondents (83%) reported that there were no pooled budgets with local council and CCGs to address sexual health, reproductive health and/or HIV needs of the local population.

Question 21: Are you required to make further financial savings in budgets for sexual health, reproductive health and HIV services for financial year 2016-17



Two thirds of respondents (67%) reported that they would be required to make further financial savings in budgets for sexual health, reproductive health and/or HIV services in the financial year 2016-17. A quarter (25%) reported that no further financial savings in budgets would be required for that year. The need to make further financial savings was reported most by North East respondents (100%, n=7) and least by East Midlands respondents (40%, n=2 of 5).



Question 22: How have you met/will you meet required financial savings in this topic area?

84% (87 out of the 103) local authorities provided a response to this question. General themes/approaches were:

Review of service specifications

The local authority took the opportunity to reduce the contract budgets (either with same service specification or with a restricted service specification). Examples include:

- Decommissioning services
- Decommissioning NCSP
- Capping mechanisms for LARC provision
- Shifting balance away from prevention or towards prevention
- Reduction in staff
- Reduction in service locations
- Re-channelling of patients to online and self-sampling pathways (less face to face services)

- Reduction in funding for training and development of staff
- Consider feasibility of 100% open access services (therefore restrict access)
- Integration of services
- Decommission clinical networks

Restructure payment mechanisms

The local authority revisited payment mechanisms. Some moved to tariff, some moved to blocks, and some started to cross charge.

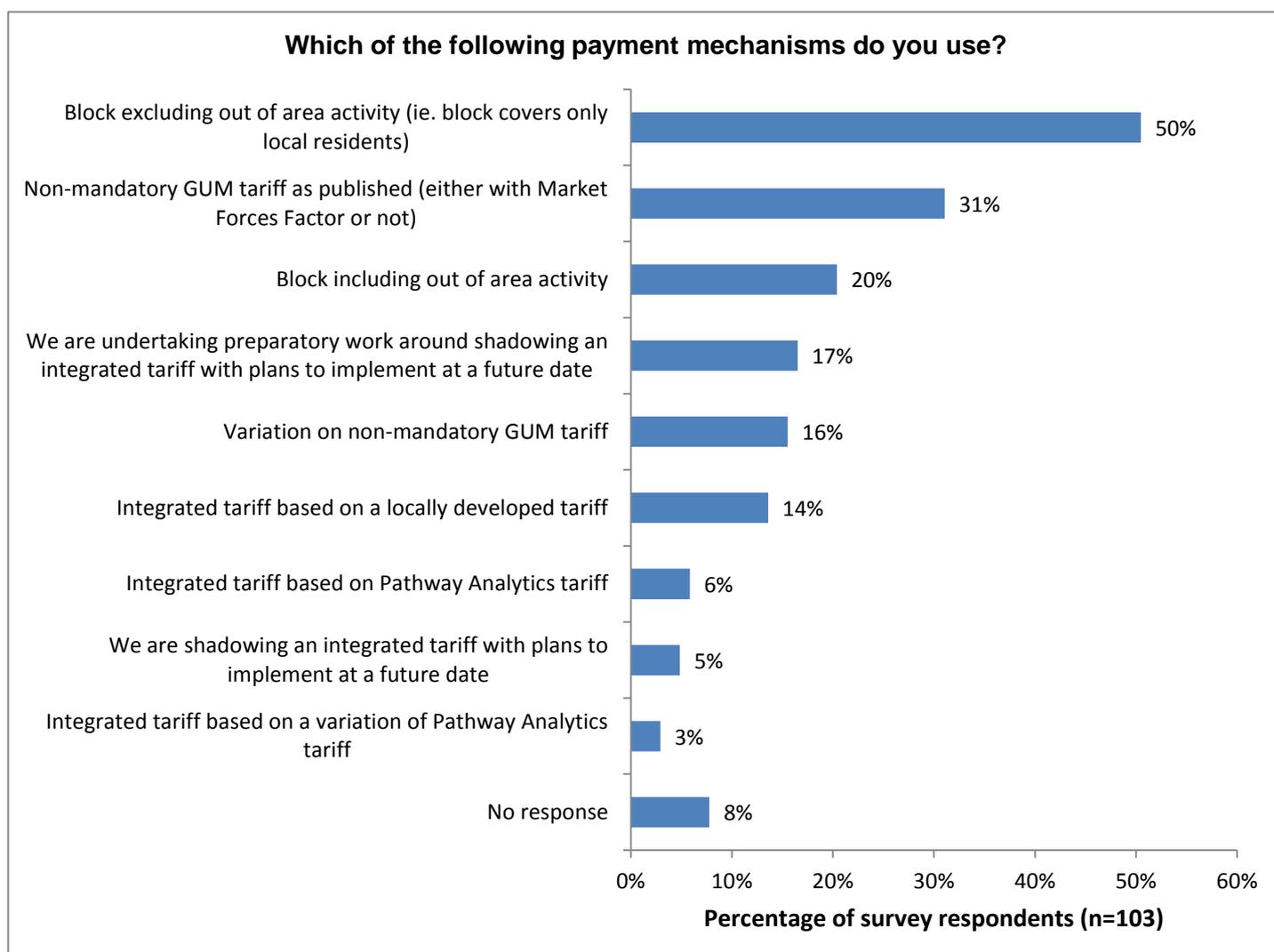
Efficiencies through collaboration

Examples include: joint commissioning, joint procurement, re-tendering with neighbours, and mainstreaming commissioning support.

1.1.9 Tariffs

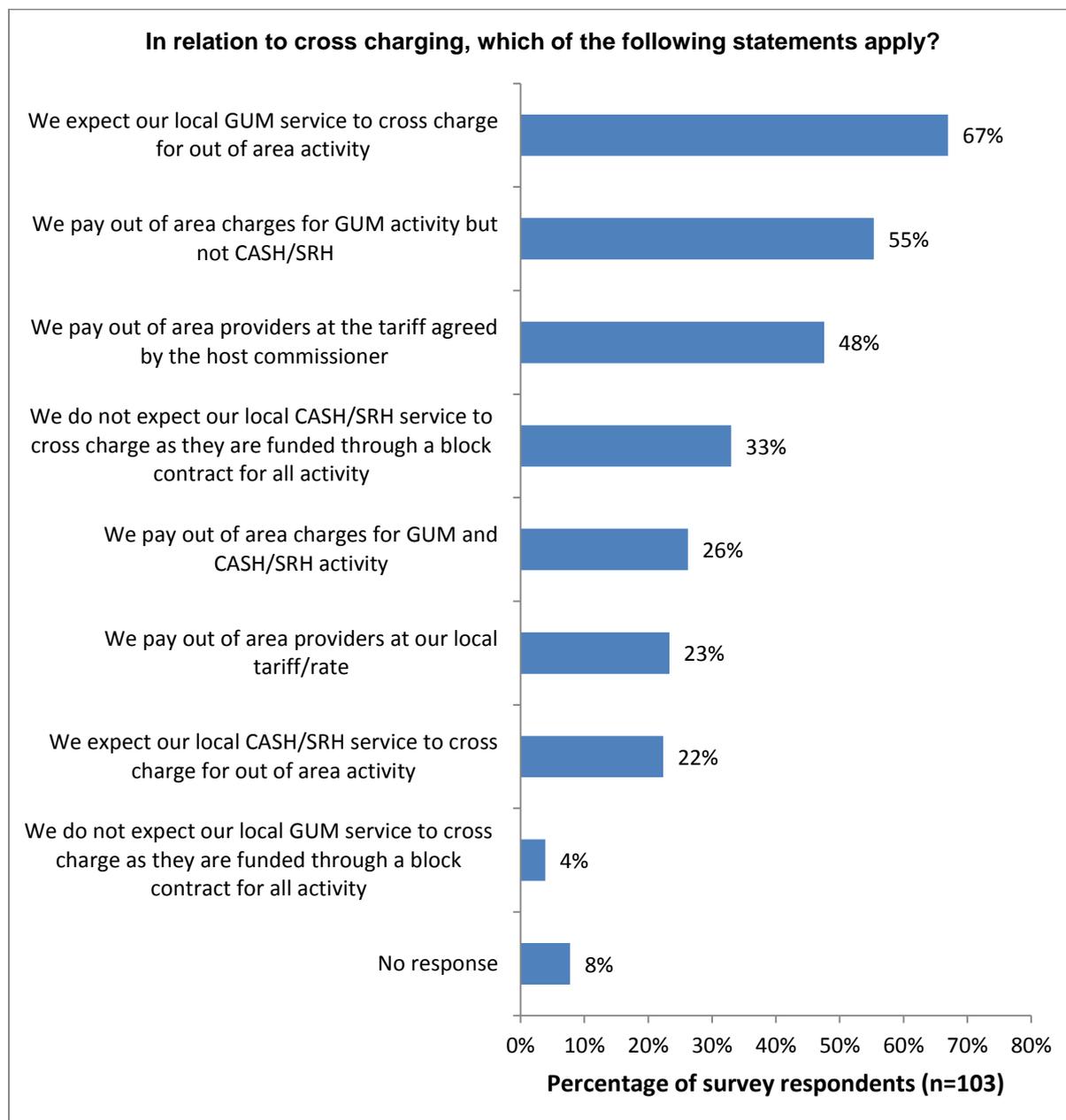
Question 23: Which of the following payment mechanisms do you use?

Local authority respondents could select multiple responses for this question. A variety, and combination, of payment mechanisms were used by the local authorities responding to the survey. The most commonly used mechanisms were block



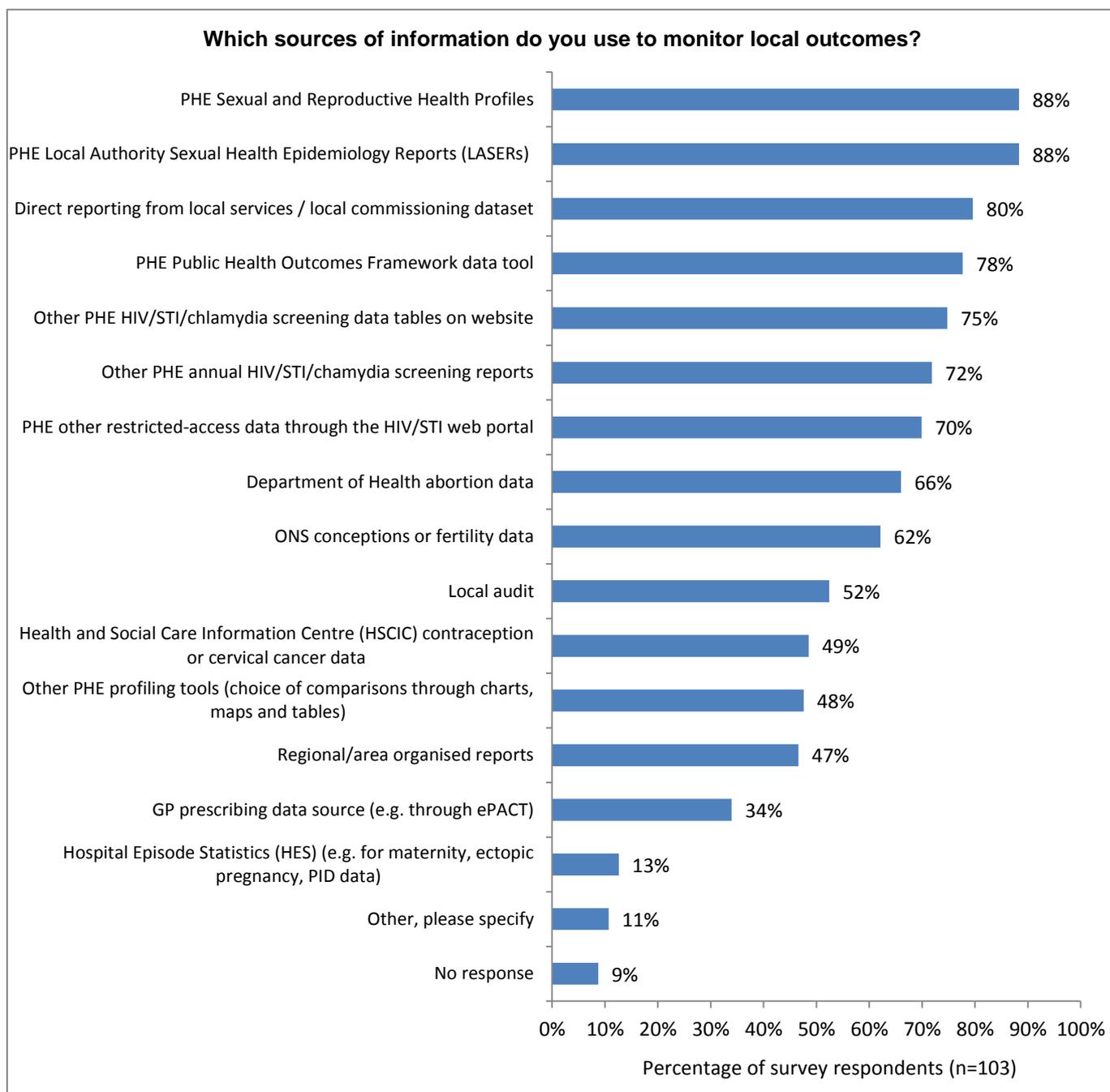
contracts which excluded out of area activity (reported by 50%) and a non-mandatory GUM tariff (reported by 31%). Integrated tariffs were less commonly used.

Question 24: In relation to cross charging, which of the following statements apply?



1.1.10 Outcomes and performance

Question 26: Which sources of information do you use to monitor local outcomes?

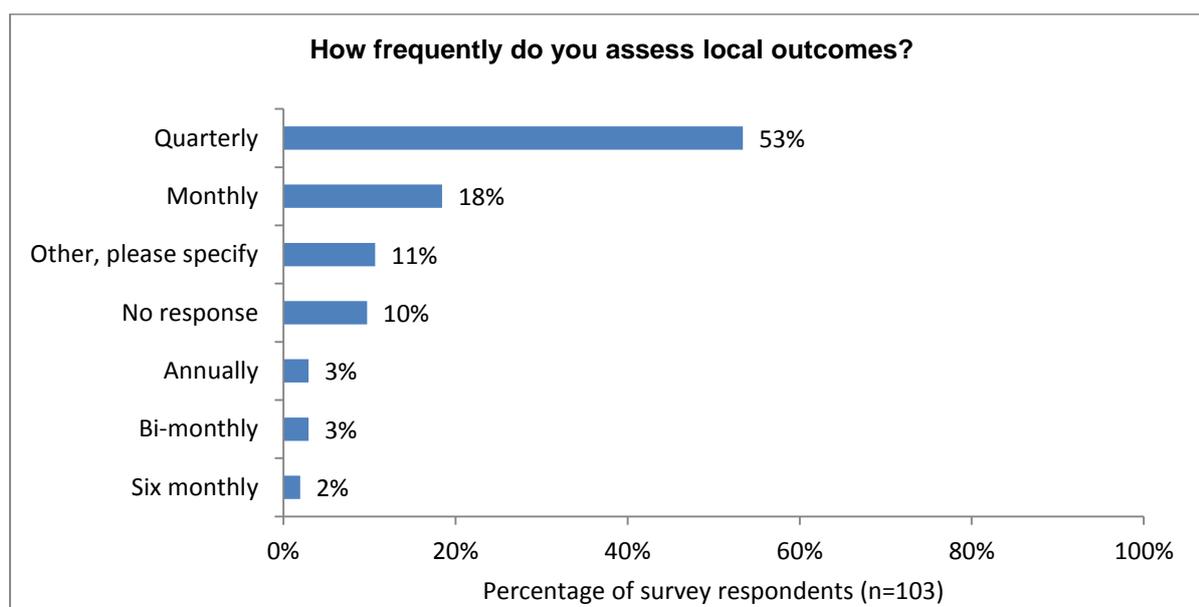


Local authority respondents could select multiple responses for this question. 88% of respondents used both the 'PHE Sexual and Reproductive Health Profiles' and 'LASER reports' to monitor local outcomes. 'Hospital episode statistics' were the least commonly used resource, with only 13% using them. Within the 'Other' response, respondents mentioned service quality reports, real time data from

maternity service and that gaining access to specific sources of information can be difficult.

Question 27: How frequently do you assess local outcomes?

Over half of respondents (53%) monitor their local outcomes on a quarterly basis. Within the 'other' response category, respondents stated that the assessment of the outcome or indicator was dependent on what was being monitored.



Question 28: What is your internal mechanism for reporting local outcomes?

90% (93 out of the 103) local authorities provided a response to this question. However, 3 of these respondents were unsure what their internal mechanism was or did not provide a clear response.

The vast majority of respondents have some internal mechanism. There were a variety of internal mechanisms mentioned by respondents and generally there was quite a lot of overlap between themes. The main themes that arose were:

Reporting to a specific performance group or board

Respondents often stated the specific group that they reported to. In some cases, this was to the Health and Wellbeing Board, but in other instances it was a sexual health specific group or a local board.

Monitoring of performance

Respondents stated that this was often achieved using management systems, through using a specific framework, in the form of a meeting, or by looking at agreed outcomes.

Through the use of reports

These were generally either internal or regional reports.

Contract review or monitoring (generally in the form of meetings)

Using a dashboard or profile tool

Where respondents stated how this was undertaken, answers included using PHE profiles, a dashboard system or a scorecard.

A JSNA or other form of needs assessment and through a delivery or service plan was also mentioned. Other meetings were mentioned by respondents, including meeting with providers or commissioners.

Question 29: If outcomes are poor, how is this managed?

88% (91 out of the 103) local authorities provided a response to this question. However, one of these respondents stated they did not know how poor outcomes were managed.

A number of responses did not state specific management options for poor outcomes as they indicated it would depend on the poor outcome as to what was instigated as a result.

Management of poor outcomes fell into a variety of categories. The following were the main themes that emerged:

Implementation of a form of remedial action

Responders stated that this was often through an action or improvement plan that may include timescales for recovery. This was the most popular theme that emerged from the responses.

Contractual mechanisms, meetings or management

These varied from meetings to understand the poor performance through to financial penalties or contract levers for a breach in contract.

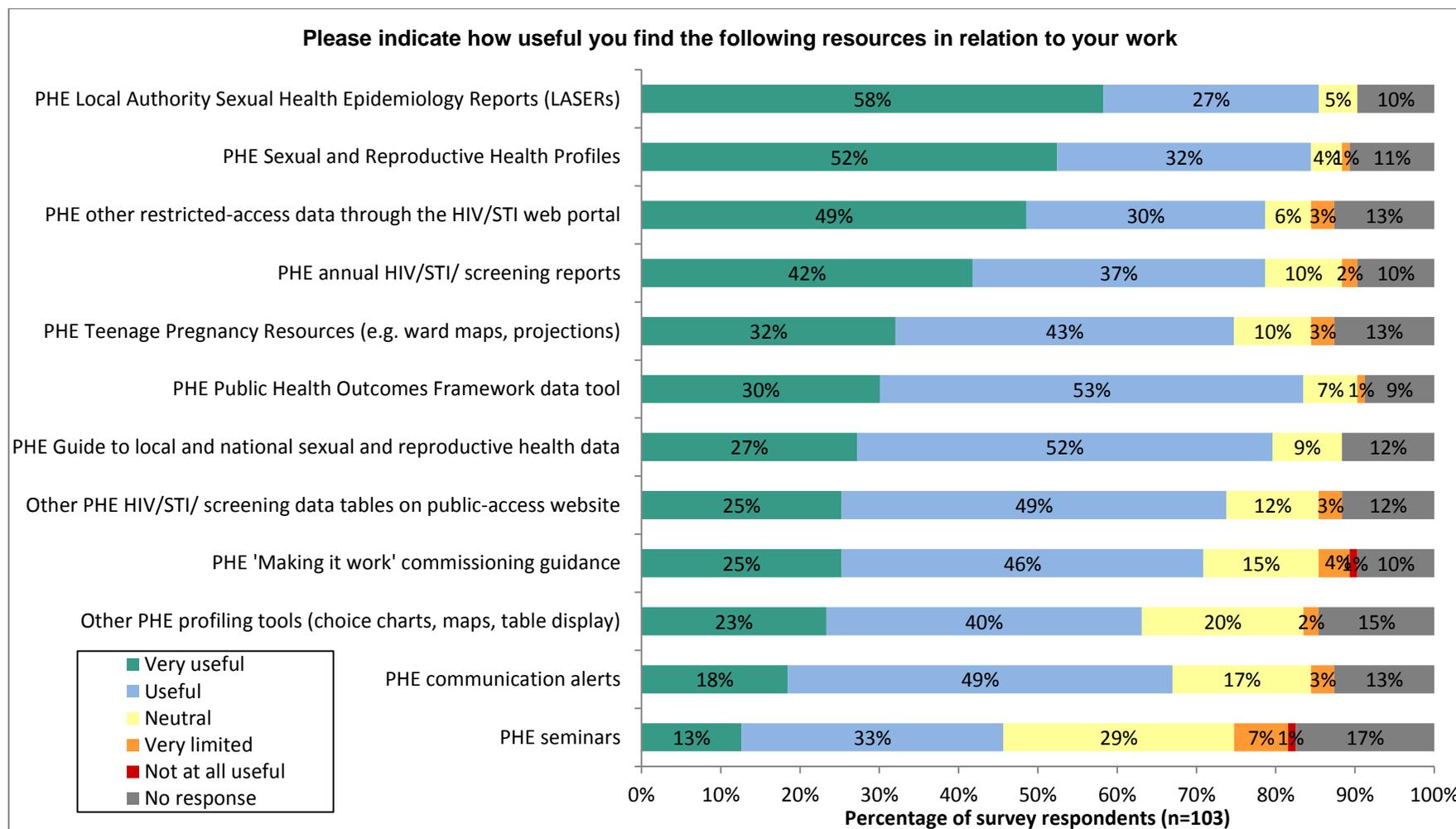
Performance management or monitoring

Responses indicated that these could be meetings on a regular basis, or monitoring through a framework or using a key set of indicators.

Other responses to managing poor outcomes included supporting the providers, to review with an advisory board or group, to use an RCA approach or a risk register, although these were themes that did not occur frequently in the responses.

1.1.11 PHE resources

Question 30: Please indicate how useful you find the following resources in relation to your work.



'PHE Local Authority Sexual Health Epidemiology Reports (LASERs)' had the highest proportion of respondents (58%) that rated them 'Very useful'. This was followed by the 'PHE Sexual and Reproductive Health Profiles' with 52% of respondents rating them 'Very useful'. Overall, 85% and 84% of respondents respectively found these two products to be either 'Useful' or 'Very useful'. 'PHE seminars' had the lowest proportion (46%) of respondents who rated them as either 'Useful' or 'Very useful'.

Question 31: What other help or support would you like from PHE?

63% (65 out of the 103) local authorities provided a response to this question, but 1 of these responses was unclear.

Respondents mentioned that they would like further help and support with:

Data

This was either further analysis of datasets, improving the quality of data or increased reporting. Data broken down by specific populations was also mentioned.

National approach to key issues

Respondents requested support in securing a national approach to key issues such as out of area payments. This was a particularly common response within this question.

Support with meetings

Respondents were either requesting representation at or input for meetings.

Support for specific areas

A number of responses stated that they would like support with specific areas, such as return on investment work or managing poor outcomes.

Clarity on PHE's role (query support)

Clarity around PHE's role centrally and locally as respondents stated that there appeared to be differing levels of support.

Support for partnership working and workforce development

Other areas that respondents mentioned they would like support included campaign resource or information and help with protecting the Public Health grant.

A number of responses also stated that they were happy with the current support that they received.

1.1.12 Top challenges and examples of good practice

Question 32: Do you have any examples of good practice that you would be willing to share?

59% (61 of the 103) local authorities provided examples of good practice that they would be willing to share, and these covered a wide range of topics including:

- integrated sexual health service specification/model of delivery and commissioning process – some highlighted the extent of services involved or their approach to the model
- collaboration, including: joint commissioning; section 75 agreement; working with the 3rd sector; out of area/cross charging; sexual health networks
- lessons learned from procurement of services – lessons for commissioners and/or providers
- GP and pharmacy contracts and specifications for locally commissioned services
- a place based approach to ensure equity of access
- long acting reversible contraception (LARC): specification, audit, tariff for insertion and removal of sub-dermal implant
- Patient Group Directions (PGD) development
- ensuring services include a strong focus on sexual health promotion
- Outreach, linking services and fast track access for at-risk populations and vulnerable people including: black Africans; South East Asian Muslim Women; refugee asylum seekers; trafficked women; children in sexual exploitation; women at risk/with child protection proceedings; those using substance misuse services; learning disabled; MSMs using saunas; young people; new teenage mothers at home; women at termination of pregnancy services; sex workers
- young people health promotion examples: PSHE work in schools; website; pharmacy C-Card; specialist sexual health pharmacy; young people clinic in primary care; linking to wider local authorities' young peoples' programmes; working with young people to develop resources
- methods for increasing HIV testing, including: home sampling kit; 'point of care testing' such as at pharmacies or medical admissions units
- increasing chlamydia screening through an online approach or use of pharmacies
- service quality: standards and review frameworks; 'You're Welcome' accreditation
- fast tracking of treatment for reactive HIV and other STI patients

- training the sexual health workforce, including pharmacists and GP HIV awareness training, and the clinical leadership/education role of specialist services
- innovative use of IT for service provision, management and review
- analysis of data relating to GP and pharmacy contracts
- sexual health needs assessment

Question 33: What are the top three challenges that you face when commissioning sexual health, reproductive health and/or HIV services?

90% (93 out of the 103) of local authorities provided a response to this question. Many reiterated responses provided for Question 15. Some responses succinctly highlighted three challenges; others elaborated with examples and/or provided more than three challenges.

There were two main themes: ‘financial challenges’ and ‘fragmentation challenges’.

Financial challenges

Reduced resources, budget cuts (cuts to the public health grant and wider reductions to local authority budgets), budget uncertainty or the need to balance resource constraints against rising demand for services were highlighted by many as a key challenge.

Increased demands included: introduction of PrEP; HPV vaccination for MSM; emerging issues such as Chemsex; increasing STI rates; and increasing cost of LARC contraceptives.

The need to maintain open access and deal with out of area cross-charging was also highlighted by many as contributing to financial challenges, for example:

“Individual LAs PH Grants will have been calculated based, in part, on the size of their block funded CaSH services. Where the LA moving to cross charging has a large CaSH service, sometimes with as much as 80% of activity of a specific clinic being people outside of their area, then they are looking at making a significant saving in their spend whilst their neighbours are challenged by cross charge bills way beyond the scope of their PH grant settlement.”

“Difficult to control budget, a lot of resources in processing invoices and having to deal with constant challenges from providers”

Fragmentation challenges

Fragmented commissioning arrangements and the need for collaborative working between commissioners and between commissioners and providers to ensure clear service pathways was a challenge for many. One respondent commented:

“Different contractual arrangements in place across local authority and CCG areas producing different models of delivery and funding, could lead to an increasing 'postcode lottery' for some services and in particular contraceptive services.

Barriers highlighted included: having to deal with a significant number of organisations, competing priorities, lack of commissioning guidance, and primary care lack of clarity and variable engagement regarding provision of contraception and cervical screening resulting in impact on secondary CaSH services. One respondent noted:

“Engaging with other commissioners responsible for sexual health - this is a small part of their responsibility so the importance placed on it is often limited”

The following four specific issues were also highlighted by a number of respondents:

Lack of clinical expertise in local authorities

Lack of clinical expertise in local authorities was highlighted as a concern by some respondents regarding ensuring adequate clinical governance, safeguarding and risk management. One respondent commented:

“We tried to engage through BASSH, but got no response from anyone on the list. We contracted in an external consultant in the end.”

Equity of access challenges

Rurality and large diverse geographies posed a challenge to equity of access to services for some respondents. Targeting and meeting the needs of high risk population groups such as young people, MSM, BME was also viewed as a challenge by others.

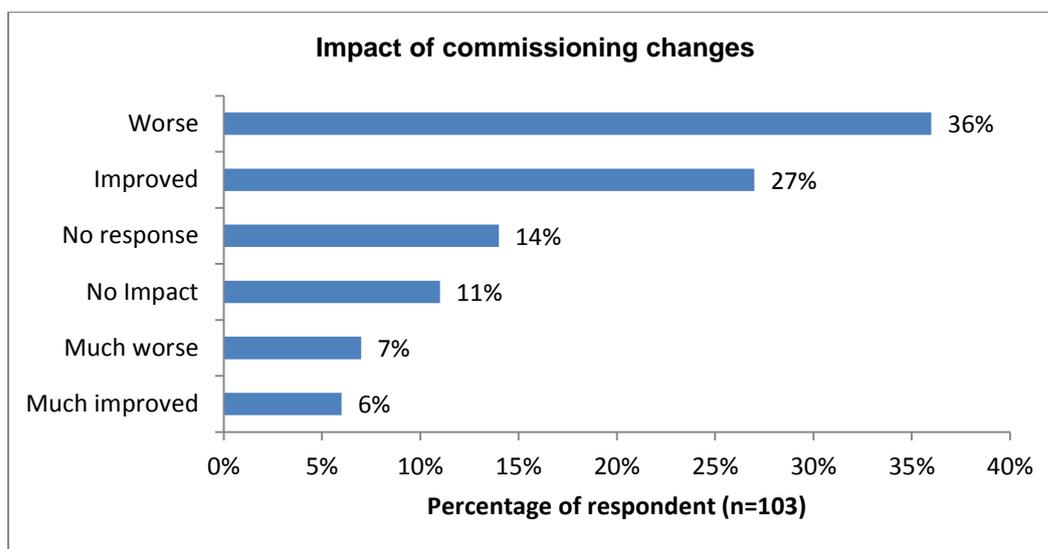
The need to fund and ensure effective prevention

Some respondents highlighted the challenge of ensuring prevention initiatives. One respondent noted the need for “changing culture within existing service to refocus on prevention”. However another noted that there was a “lack of funding to invest in prevention.”

The challenge to drive change and innovation

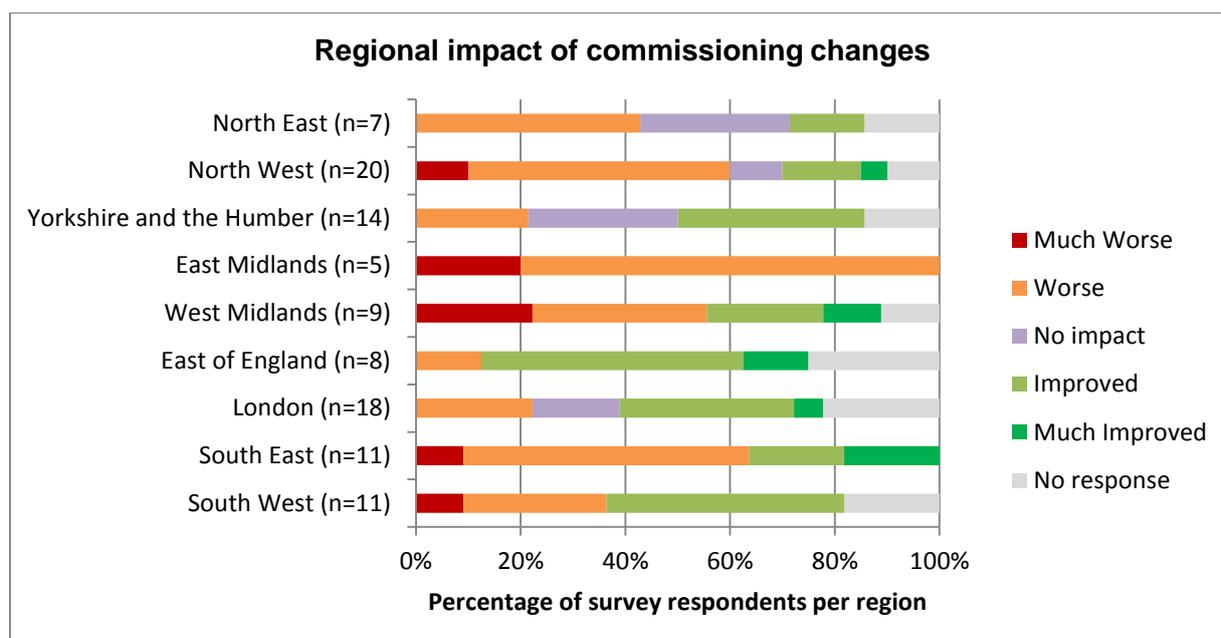
Some respondents noted the challenge of procurement in a limited market and difficulty encouraging change and innovation. One respondent noted “difficulty getting Provider to grasp vision and invest in innovation”.

Question 34: What impact have the commissioning changes introduced in April 2013 had on the sexual health, reproductive health and HIV system in your local area?



43% of the local authority respondents indicated that the commissioning changes in April 2013 had had a worse or much worse impact on the local HSRH commissioning system. A third (33%) of respondents indicated that the system had improved or much improved.

The change was viewed most negatively in the East Midlands (100% worse/much worse, n=5) & most positively in the East of England (63% improved/much improved, n=5 of 8).



67 respondents provided further details.

For those local authorities viewing the changes as worse/much worse, fragmentation of commissioning and cost pressures were main themes and several responders highlighted resulting problems with:

- fragmented service/pathways, for example: “Has created gaps in some services and cost shifting”
- getting an overview and ability to control/co-ordinate, for example: “The split in commissioning responsibilities in particular HIV (NHSE) and abortion (CCG) makes it more difficult to have oversight of these services”
- dealing with multiple commissioners, for example: “Working closely with the 7 CCGs on TOP is proving very difficult”
- working with providers, for example: “More difficult for local commissioners and providers to work together; difficulties caused by separation of commissioning of HIV and SH services”
- competing priorities, for example: “Services are only delivered/prioritised if they fit within the financial envelope of the relevant organisation. These services are no longer a priority for most organisations”
- leaving the NHS resulting in issues such as lack of medical expertise/oversight or ability to exert influence within the NHS system, for example: “Scant and decreasing human resource and knowledge in local authorities for exercising sufficient competence in regard to clinical governance and quality, medicines management issues etc.”

For those local authorities viewing the changes as improved/much improved, several responders highlighted improvements such as:

- ability to integrate/align services, for example: “Has given an opportunity to retender for an integrated sexual health service under a prime provider model”
- better services/outcomes, for example: “The biggest impact has been on those most vulnerable via outreach and fast track access and pathways”
- more control/accountability, for example: “The integrated SH service is now more accountable and has greater clarity of roles and responsibilities due to refreshed spec”
- more cost effective/streamlined, for example: “A better focus on integrated sexual health and cost effective delivery mechanisms”
- able to draw on benefits of being in a local authority environment, for example: “Working within a different procurement environment in local authority has improved the commerciality and governance of the public health team and improved how contracts are planned and monitored”

However, whether respondents indicated worse, improved or no impact overall, many responses provided a mixed picture of concerns and benefits.

1.1.13 Further comments

Question 35: If you have any further comments please elaborate in the space provided below.

17% (18 out of the 103) local authorities provided further comments. These were varied, but the majority reiterated themes and issues highlighted in the analysis of responses to earlier questions.

One particularly critical response included additional comments relating to the perceived priority of sexual health:

“The changes of 2013 have been an unmitigated disaster - urgent action is needed to remedy the challenges. SSH contracts generate huge transaction costs for non NHS organisations such as local authorities. The 'noise' generated by BASH (*sic*) et al and the national political response have mitigated against the ability to effect transformational change at a local level. This is compounded by a lack of national willingness to review the overall spend on SH/service provision in a climate of severe budgetary challenge. Local politicians see the level of spend on SH services as disproportionate to the benefits compared to other services and the pressure to reduce what are seen as 'nice to do' services is huge and will only get greater when the ring fence is removed.”

However, there were also positive comments, such as the benefit of being in a local authority:

“Being in local authority has also changed how we engage with the public and increased accountability which acts as a driver for the public health team to continue to improve on delivery of services to better meet the needs of the local community and improve the local health outcomes”.

Additional comments relating to potential solutions or sources of support included:

Ring fence sexual health budgets:

“Suggest sexual health budgets are ring-fenced to ensure services are not jeopardised in the future. Locally we have a good service, but I think to cut the budget further would jeopardise the quality and ability of the provider”.

Department of Health to resolve the cross-charging issue:

“DOH should not shy away from issuing consolidating cross charging guidance or preferably policy - something concrete. In order to save money in the long term across the whole system it is recommended that there is a no cross charging policy and to work out budgets according to general patient flows.”

PHE could do more:

“What are PHE doing in the light of the results to change the system of sexual health commissioning and to ensure equity in access, improved outcomes and reduction in the incidence and prevalence of sexually transmitted infections and disease?”

“PHE could do more to be a critical friend in assessing performance, rather than passive receipt of data like LASERS, which are really useful but don't do enough to provide an external challenge to local systems”

“The changing commissioning landscape in the light of both the Health & Social Care Act and the move towards devolution present both challenges and opportunities for which PHE will be able to play a key role in offering support”

Encourage regional commissioning:

“Every opportunity to deliver regional commissioning should continue to be considered and encouraged”.

Provide clinical support:

“Commissioners need more support to understand & solve problems that are linked to clinical aspects/limitations”.

Commissioning forum useful, for example:

“We find the national and regional sexual health commissioners’ forum useful to share practice and deal effectively with key issues, and it provides a good support network”.

1.2 NHS England

1.2.1 Response rate

Five NHS England (NHSE) responses were received, with two of the responses received from the same NHS England regional office. These represent nearly a third (31%) of the 13 NHS England regional offices, and two of the four NHS commissioning regions: 'North of England' and 'Midlands and East of England'.

1.2.2 Commissioning support

Question 4: Does your organisation commission sexual health, reproductive health and/or HIV services on behalf of other organisations?

Four of the five responses stated that they do not commission sexual health, reproductive health and/or HIV services on behalf of other organisations. The remaining response stated 'Don't know'.

Question 5: Do any organisations commission sexual health, reproductive health and/or HIV services on behalf of your organisation?

Three of the five responses stated that no other organisations commissions services on behalf of the organisations who responded to the survey. One stated that they did not know, whilst the other selected 'Yes' and stated that this was HIV care and treatment.

Question 6: Does your organisation use the services of a commissioning support unit/hub?

Four of the five responses stated that they used a commissioning support unit or hub, whilst one stated that they did not.

1.2.3 NHSE commissioned services

Question 7: Which services are you responsible for commissioning on behalf of your organisation?

NHSE respondents were able to select multiple responses for this question. Five responses were provided and the number of respondents who selected each option was:

- ‘HIV care and treatment services commissioned from specialist providers’: two of five
- ‘HIV care and treatment services provided to patients in detained settings’: one of five
- ‘Sexual Assault Referral Centres (SARC)’: one of five
- ‘Cervical screening’: three of five
- ‘HPV immunisation’: three of five
- ‘Specialist foetal medicine services’: one of five
- ‘Infectious diseases in pregnancy screening programme’: three of five

Additional services that were mentioned by respondents included ‘Section 7A Public Health Services’ and ‘Breast Screening’.

1.2.4 Needs assessment

Question 8: Have you used a relevant needs assessment in specifying the sexual health, reproductive health and/or HIV service(s) that you commission?

Two NHSE respondents stated that they had not used a relevant needs assessment. Two respondents had performed a needs assessment in 2015 and the remaining respondent had performed one in 2014.

1.2.5 Sub-populations

Question 9: Please indicate, for the sexual health, reproductive health and/or HIV services that you commission, if you have any specific requirements for these sub-populations.

Only two NHSE responses were provided for this question. However, one respondent selected ‘Not undertaken or unsure’. The other respondent selected ‘People with learning disabilities’ and ‘People with mental health problems’ as sub-populations with specific requirements.

1.2.6 Service Specification

Question 10: Do you use any of the following service specifications?

NHSE respondents were able to select multiple responses for this question. Five responses were provided and the number of respondents who selected each option was:

- ‘NHS England Standard Service Specification for HIV services (adults)’: two of five
- ‘NHS England Standard Service Specification for HIV services (children)’: two of five
- ‘Locally developed service specification’: two of five

Additional specifications that were mentioned by respondents included: ‘Section 7A specifications’ and ‘NHS England cervical screening and breast screening service specifications’.

Question 11: Have you used any of the following to develop your service specifications?

NHSE respondents were able to select multiple responses for this question. However, only two responses were provided and one selected ‘Other’ and stated that the “specifications are developed at national level”. The other respondent selected ‘Public Health Outcome Framework Indicators relating to sexual health, reproductive health and/or HIV’, ‘Standards contained within the British Association of Sexual Health and HIV (BASHH) Standards for the management of sexually transmitted infections document’, and ‘Standards contained within the British HIV Association (BHIVA) Standards of care for people living with HIV document’ and also stated that they used “archived online PHE relevant documents”.

Question 12: Do you have any locally identified needs that are not met by your existing service specification(s)?

Two NSHE respondents provided an answer for this question and these responses both selected ‘Yes’. One stated “data quality and performance schedules need to align” and the other said “annual HIV cervical screening”.

1.2.7 Access to services

Question 13: Do you commission any of the following to be provided through GENERAL PRACTICE?

Three NHSE responses were provided. All of these stated that this question was ‘Not relevant’ to them.

Question 14: Do you commission any of the following to be provided through PHARMACY?

Three NSHE responses were provided. All of these stated that this question was 'Not relevant' to them. These were the same respondents as for question 13.

Question 15: Does your organisation have any concerns about current or future access to sexual health, reproductive health and/or HIV services provided in your area? These could be in Primary Care or in Specialist settings. If so, please provide details.

Two NHSE responses were provided:

“Yes, opportunistic cervical screening should be maintained in sexual health clinics as an integrated element of the service, commissioned by LAs.’
‘Risk of local authority commissioning processes destabilising provision of HIV Treatment & Care services.’”

1.2.8 Tendering

Question 16: When was the last time that NHS England assessed specialised services against its published service specification?

Four NHSE responses were provided for this question. Three respondents stated that they had assessed specialised services since April 2013. One selected 'Don't know' and stated that it was not relevant.

Question 17: Is your organisation planning any market testing or service review that would affect the current provider landscape?

Four NSHE responses were provided for this question. Two stated that they would be planning market testing or a service review "within the foreseeable future"; whilst one said they had "no plans" and the fourth stated "don't know". Although no dates were provided where the answer was "within the foreseeable future", one stated that this would be "for relevant services only".

Question 18: Please describe any issues around commissioning across patient care pathways with commissioners of other parts of the system.

There was only one NHSE response to this question: "lack of engagement, lack of willingness, lack of clarity".

1.2.9 Re-tendering – changes to investment

Question 19: In terms of ongoing investment in sexual health, reproductive health and/or HIV services in the area that you are responsible for, please indicate if there has been any change.

Four NHSE responses were provided for this question. No respondent indicated that there was an increased investment. Two answered that there was "similar investment", and the other two answered that there was a "decrease in investment".

Question 20: Are there any pooled budgets between local councils/Clinical Commissioning Group/NHS England to address sexual health, reproductive health and/or HIV needs of the local population?

Four NHSE responses were provided for this question. No respondent said that pooled budgets existed, and one provided a free text response that NHSE in the North West had no plans to engage in joint commissioning arrangements for HIV and

sexual Health. Two respondents stated that pooled budgets did not exist, and the other two stated that they did not know if pooled budgets existed.

Question 21: Are you required to make further financial savings in budgets for sexual health, reproductive health and HIV services for financial year 2016-17?

Four NHSE responses were provided for this question. Two stated that this was 'Not relevant' for them. One respondent answered "Yes", one answered "No".

Question 22: How have you met/will you meet required financial savings in this topic area?

Two NSHE responses were provided for this question, but one stated that this was 'Not relevant'. The other respondent provided the following details:

"We are apportioning a fair share of the Specialised Commissioning QIPP target to HIV services. This is likely to be delivered largely through efficiencies with drugs."

1.2.10 Tariffs

Question 23: Which of the following payment mechanisms do you use?

Three NHSE responses were provided for this question. One area used local tariff arrangements. The other two areas used a combination of local tariff arrangements and block contracts.

Question 24: In relation to cross charging (assuming sufficient backing data is provided) which of the following statements apply?

The two NHSE responses to this questions stated that cross charging was not relevant to them.

Question 25: Do the methods you selected in the questions above deliver an effective payment mechanism?

Three NHSE responses were provided for this question. One responded that the payment mechanisms were effective for them. The other two respondents did not know whether or not the payment mechanisms they used were effective.

1.2.11 Outcomes and performance

Question 26: Which sources of information do you use to monitor local outcomes?

Three NHSE respondents provided answers to this question and could select multiple responses. Sources of information that were selected included: 'PHE Public Health Outcomes Framework data tool', 'PHE other restricted-access data through HIV/STI web portal', 'Health and Social Care Information Centre (HSCIC) contraception or cervical cancer data', 'Direct reporting from local services/local commissioning dataset', 'Local audit' and 'Regional/area organised reports'.

Question 27: How frequently do you assess local outcomes?

Three NHSE responses were provided for this question. Two respondents stated that outcomes were assessed quarterly and one that stated they were assessed monthly.

Question 28: What is your internal mechanism for reporting local outcomes?

Only one NHSE response was given for this question. The internal mechanism that was stated was 'Monthly meetings'.

Question 29: If outcomes are poor, how is this managed?

As with the previous question, there was only one NHSE response. This was 'Action plans and mitigation'.

1.2.12 PHE Resources

Question 30: Please indicate how useful you find the following resources in relation to your work.

There were two NHSE responses for this question, with the majority of feedback being 'Neutral'. However, a number of resources were also rated as 'Useful' – these included 'PHE 'Making it Work'', 'Commissioning guidance', 'Other PHE profiling tools (choice charts, maps, table display)', 'PHE communication alerts' and 'PHE seminars'.

Question 31: What other help or support would you like from PHE?

No NHSE responses were provided for this question.

1.2.13 Top challenges

Question 32: Do you have any examples of good practice that you would be willing to share?

One NHSE respondent indicated that they had an example of good practice to share but did not provide further details in the response.

Question 33: What are the top three challenges that you face when commissioning sexual health, reproductive health and HIV (this could include risk areas or areas of concern)?

There was only one NHSE response and this indicated that the question was 'Not relevant'.

Question 34: What impact have the commissioning changes introduced in April 2013 had on the sexual health, reproductive health and HIV system in your local area?

There were only two NHSE responses and these both indicated that the situation was now 'Worse'.

1.2.14 Further comments

Question 35: If you have any further comments, please elaborate in the space below:

There were no further NHSE comments.

1.3 CCGs

Note that as there were a relatively small number of CCG respondents, the following charts all present responses to options in the same order as the questionnaire rather than in order of magnitude of responses.

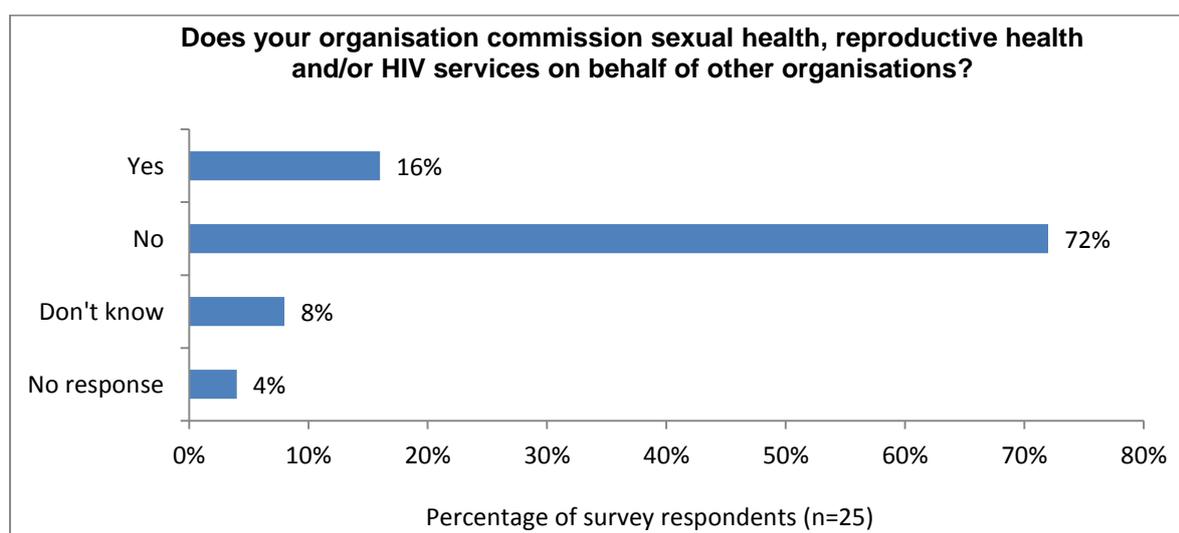
1.3.1 Response rate

25 (12%) of the 209 CCGs in England provided a response to the survey. There were no responses from London or Wessex in the South of England. Otherwise, there was a good spread of representation across the remaining NHS England regional office areas. Regarding the overall ‘NHS commissioning regions’, 11 (44%) of the 25 responses were from the North of England, 7 (28%) were from the Midlands and East of England, and 7 (28%) were from the South of England.

Following the analysis of these responses, an additional single response was sought and obtained on behalf of all London CCGs. This London CCGs’ response is shown separately as a statement for each question in this report.

1.3.2 Commissioning support

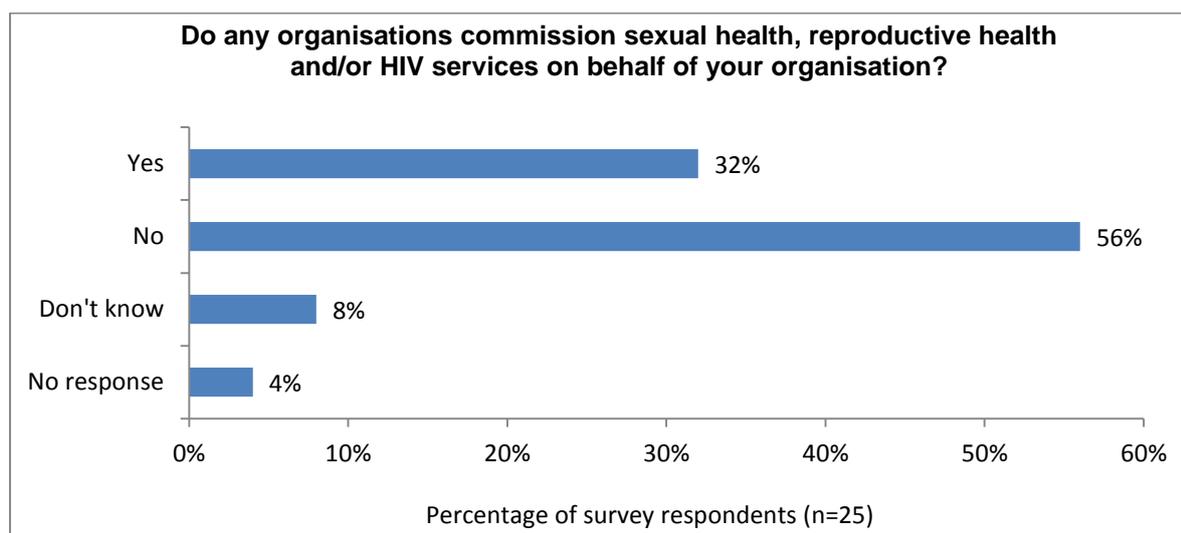
Question 4: Does your organisation commission sexual health, reproductive health and/or HIV services on behalf of other organisations?



Under a fifth (16%) of CCG respondent stated that they commissioned sexual health, reproductive health and/or HIV services on behalf of other organisations.

Where the response was ‘Yes’, respondents were permitted to enter further details if appropriate. “Termination of pregnancies”, “vasectomies”, “chlamydia screening” and “psychosexual counselling” were mentioned as services commissioned by CCGs. The London CCGs’ response stated that they do not commission these services on behalf of other organisations.

Question 5: Do any organisations commission sexual health, reproductive health and/or HIV services on behalf of your organisation?



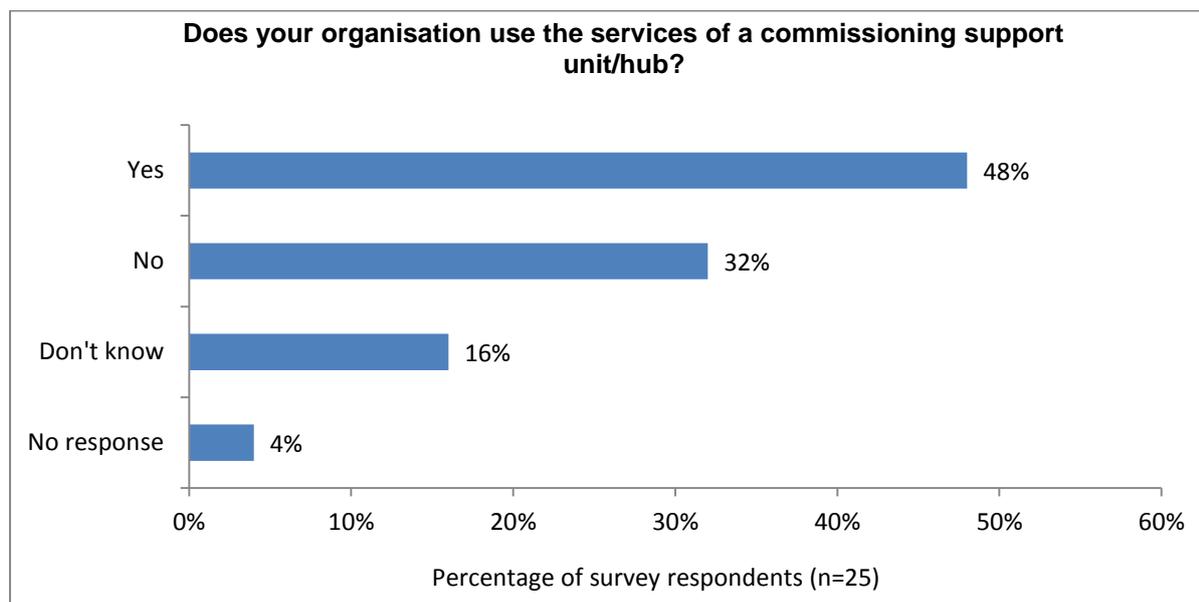
A third of CCG respondents (32%) stated that other organisations commissioned these services on behalf of their organisation.

Where the response was ‘Yes’, respondents were permitted to enter further details if appropriate. A few provided further details indicating variously:

- sexual health and HIV services
- contraception
- termination of pregnancy services (including STI, HIV and contraception)
- male and female sterilisation
- non-sexual health aspects of psychosexual health services
- HIV testing in CCG commissioned services (eg A&E)
- contraception for gynaecological services

The London CCGs’ response stated that the CCGs do not have services commissioned on behalf of their organisation.

Question 6: Does your organisation use the services of a commissioning support unit/hub?



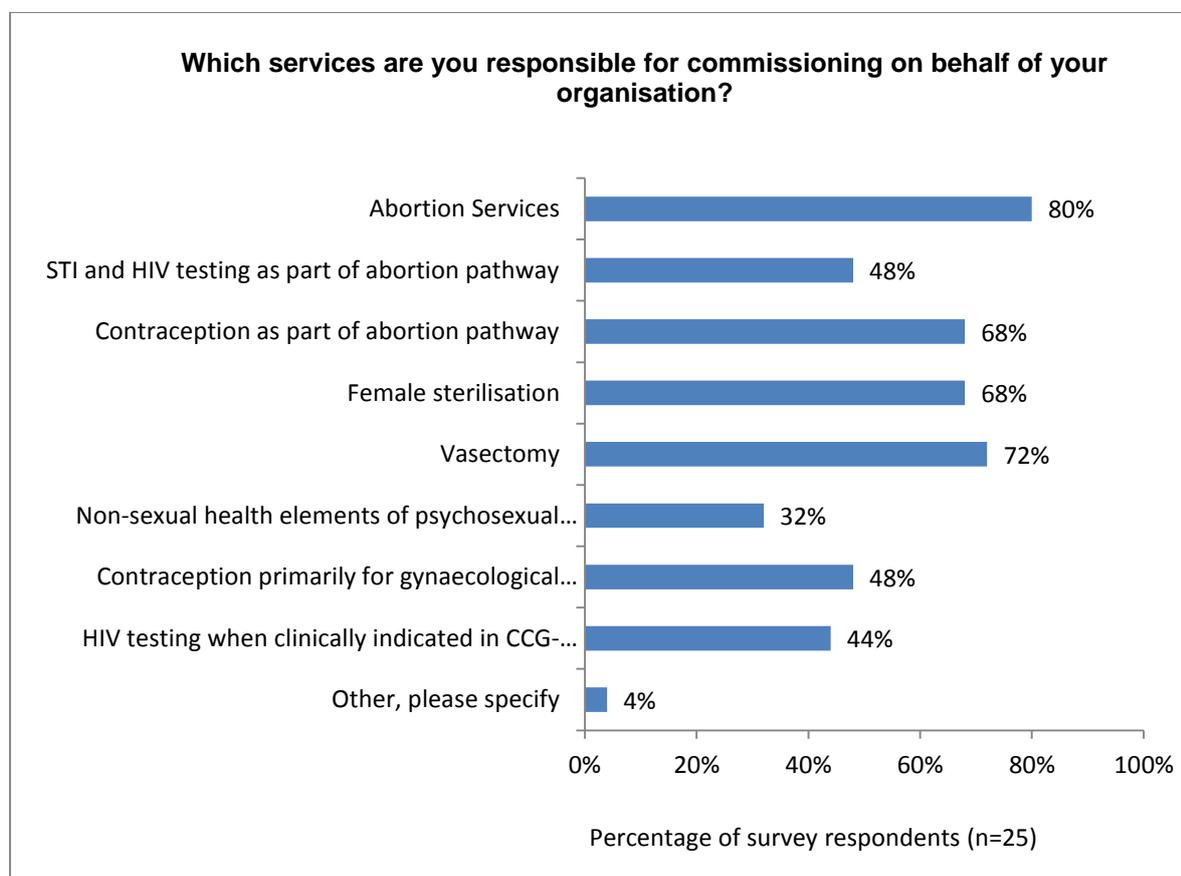
Nearly half the CCG responses (48%) stated that they used a commissioning support unit or hub.

Where the response was 'Yes', respondents were permitted to enter further details if appropriate. The majority of details provided just stated which commissioning support unit or hub was used. However one respondent noted that it was used for a specific service: "Termination services commissioned as part of an integrated specification with PH and NHSE", and another noted: "Lead commissioning sits with the CCG. CSU will provide specialist support where required, particularly finance and procurement advice."

The London CCGs' response stated that they did not know.

1.3.3 CCG commissioned services

Question 7: Which services are you responsible for commissioning on behalf of your organisation?

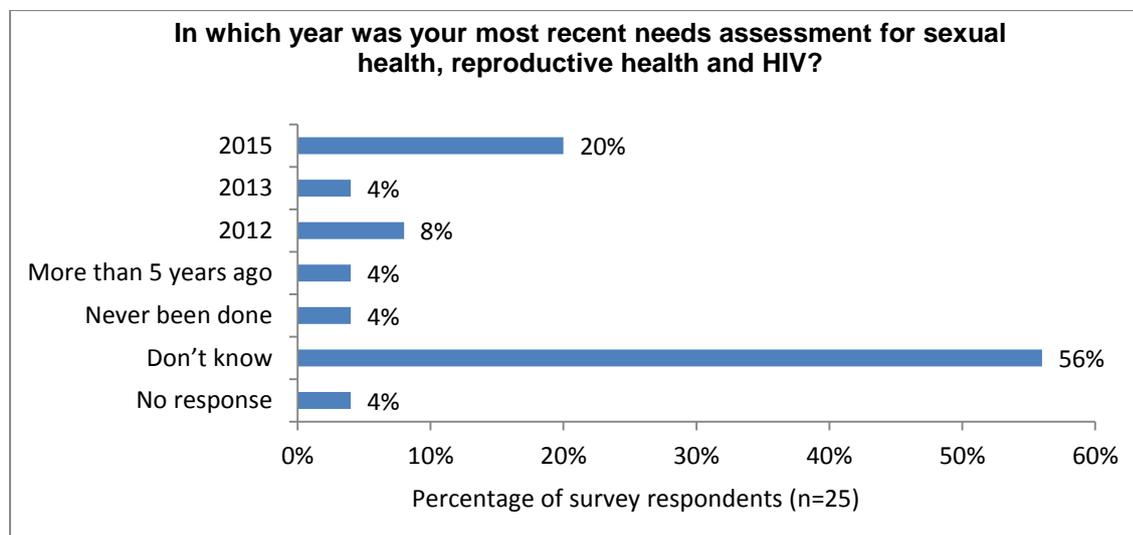


CCG respondents could select multiple responses for this question. The most common response, selected by four fifths (80%) of respondents, was ‘Abortion services’. ‘Vasectomies’ (72%), ‘Contraception as part of the abortion pathway’ (68%) and ‘Female sterilisation’ (68%) were the next most common responses. One respondent provided an additional response in ‘Other, please specify’, which stated that they were responsible for commissioning needs assessments for “erectile dysfunction”.

The London CCGs’ response stated that they were responsible for commissioning: ‘Abortion services’, ‘STI and HIV testing as part of the abortion pathway’, ‘Contraception as part of the abortion pathway’, ‘Contraception primarily for gynaecological purposes’ and ‘HIV testing when clinically indicated in CCG-commissioned services’.

1.3.4 Needs assessment

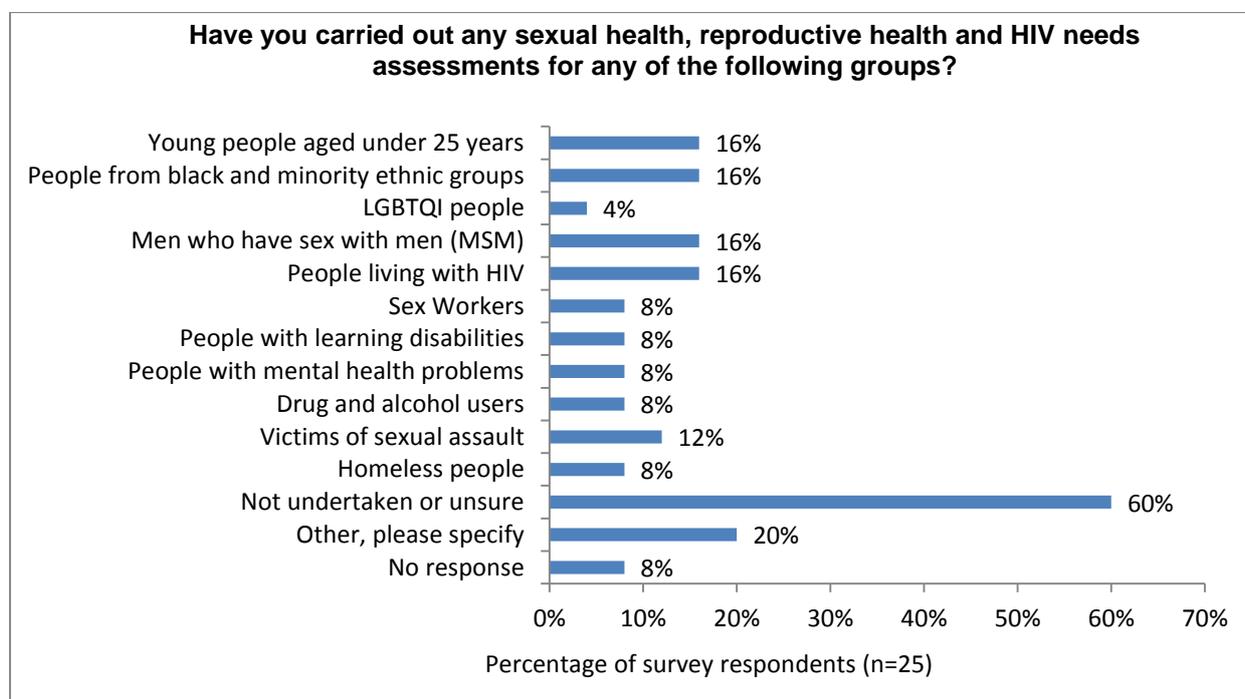
Question 8: In which year was your most recent needs assessment for sexual health, reproductive health and HIV?



Nearly three fifths (56%) of CCG respondents did not know when their most recent needs assessment had been undertaken. One respondent stated that they had never undertaken a needs assessment and another stated that their last was over 5 years ago. One respondent did not provide any information for this question. The London CCGs' response stated that they did not know when the most recent needs assessment had been carried out.

1.3.5 Sub-populations

Question 9: Have you carried out any sexual health, reproductive health and HIV needs assessments for any of the following groups?



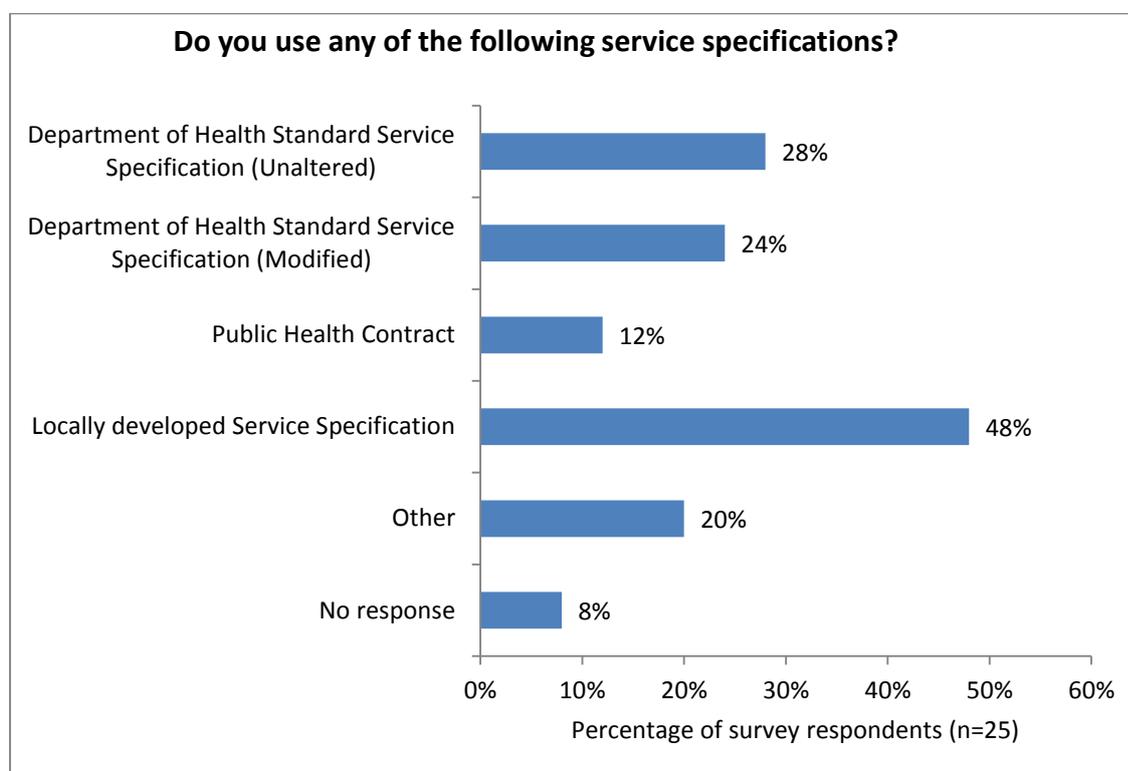
CCG respondents could select multiple responses for this question. Three fifths (60%) stated that either a needs assessment had not been carried out for these groups or that they were unsure. A fifth (20%) selected the 'Other, please specify' option and the majority of these respondents noted that need assessments had been carried out or commissioned by public health.

However, all options were selected at least once, with four responses each for 'Young people aged under 25 years', 'People from black and minority ethnic groups', 'Men who have sex with men (MSM)' and 'People living with HIV'.

The London CCGs' response stated that it would be different in different CCGs.

1.3.6 Service Specification

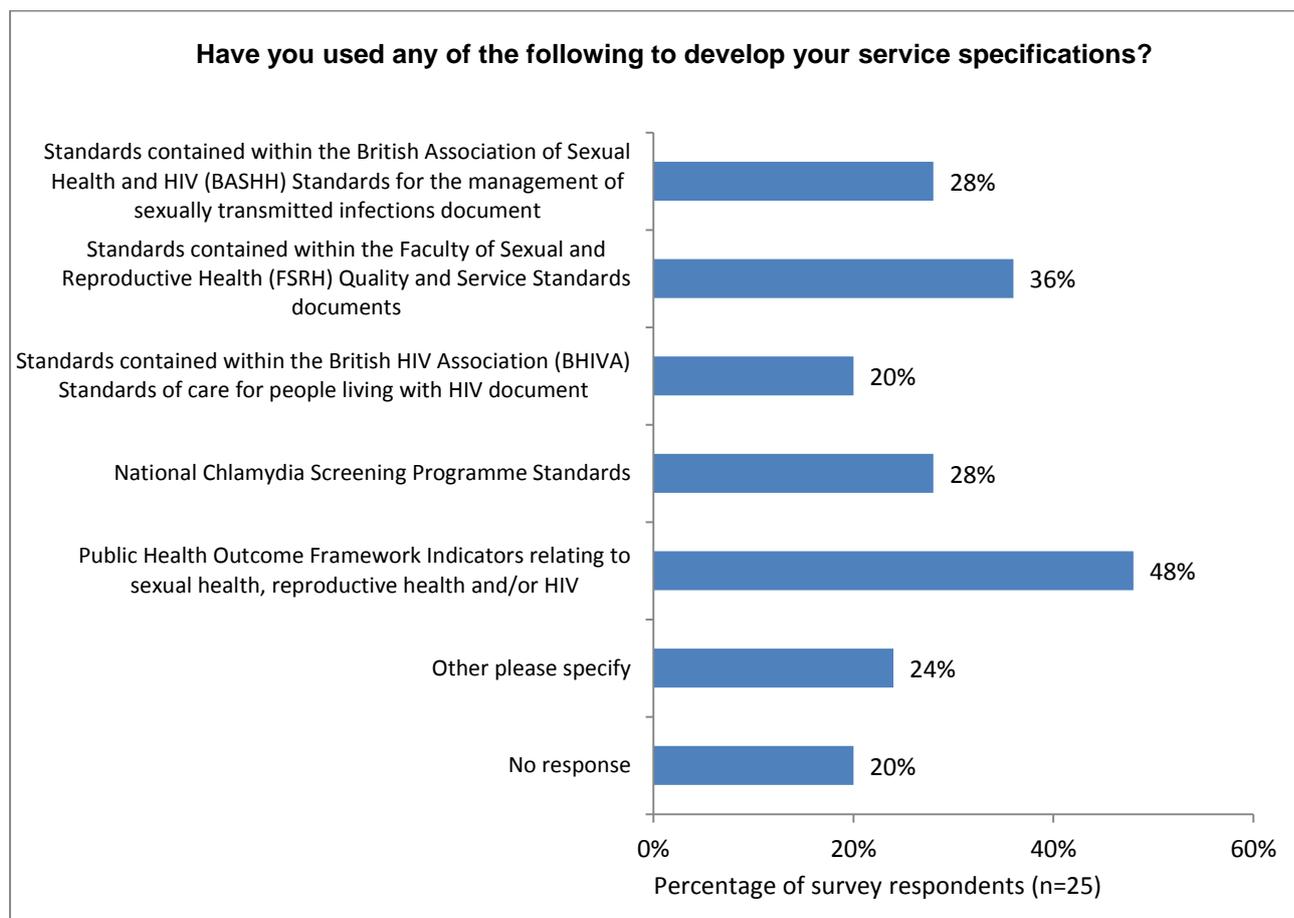
Question 10: Do you use any of the following service specifications?



CCG respondents could select multiple responses for this question. Nearly half (48%) stated that they used a 'Locally developed service specification'. Over a quarter (28%) selected the 'Department of Health Standard Service Specification (unaltered)' and about a quarter (24%) chose the 'Department of Health Standard Service Specification (modified)'. Within the 'Other' category, one respondent stated that the local specification was adapted from a national template, one had never signed off their service specification and the remainder stated that they did not commission sexual health services.

The London CCGs' response stated that they used the 'Department of Health Standard Service Specification (modified)'.

Question 11: Have you used any of the following to develop your service specifications?

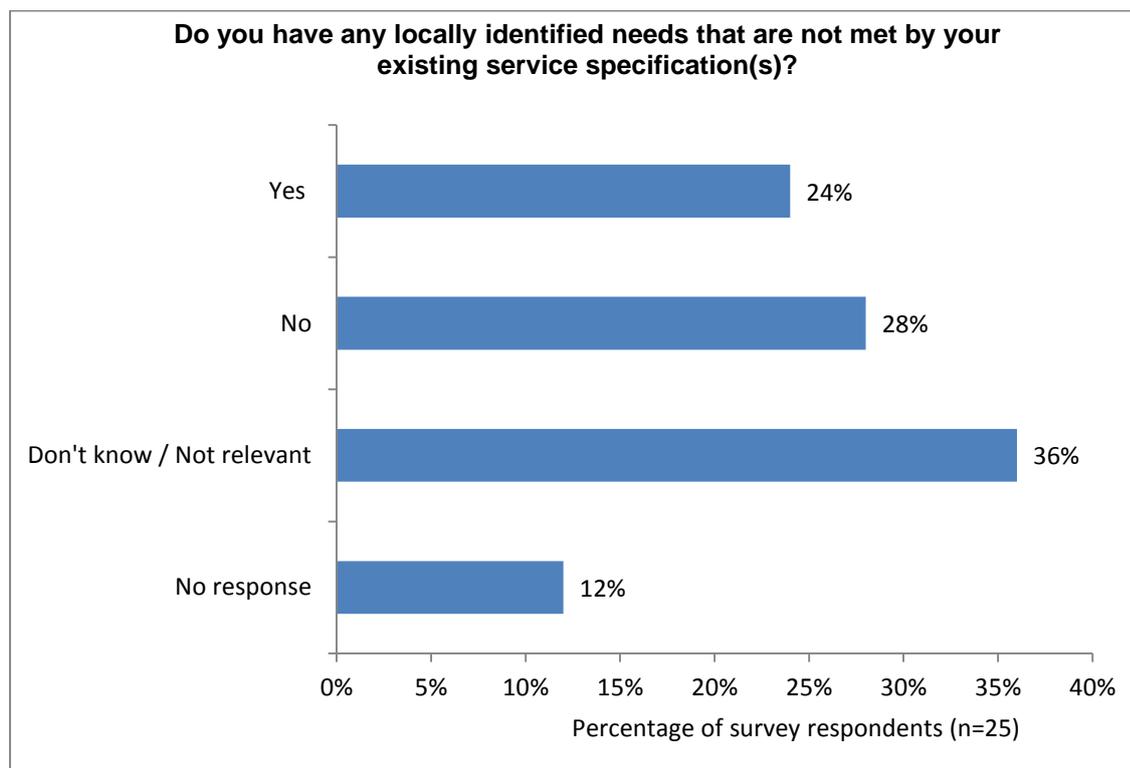


CCG respondents could select multiple responses for this question. Nearly half (48%) said that they had used the ‘Public Health Outcome Framework Indicators relating to sexual health, reproductive health and/or HIV’ to develop their service specifications. Over a third (36%) had used ‘Standards contained within the Faculty of Sexual and Reproductive Health (FSRH) Quality and Service Standards Documents’. The least commonly used (20%) was ‘Standards contained within the British HIV Association (BHIVA) Standards of care for people living with HIV document’.

Within the ‘Other, please specify’ category, one respondent stated that they used national guidelines for the termination of pregnancy provision, another used RCOG’s ‘The care of women requesting induced abortion (evidenced based clinical guideline number 7)’, and one respondent stated that they did not know as they did not develop the specifications.

The London CCGs’ response stated that they used all of these to develop their service specifications.

Question 12: Do you have any locally identified needs that are not met by your existing service specification(s)?



Over a third of CCG respondents (36%) stated that they did not know of any locally identified needs not met by their existing service specification or that it was not relevant. A quarter (24%) of respondents stated that they did know of locally identified needs and they were permitted to enter further details. These included:

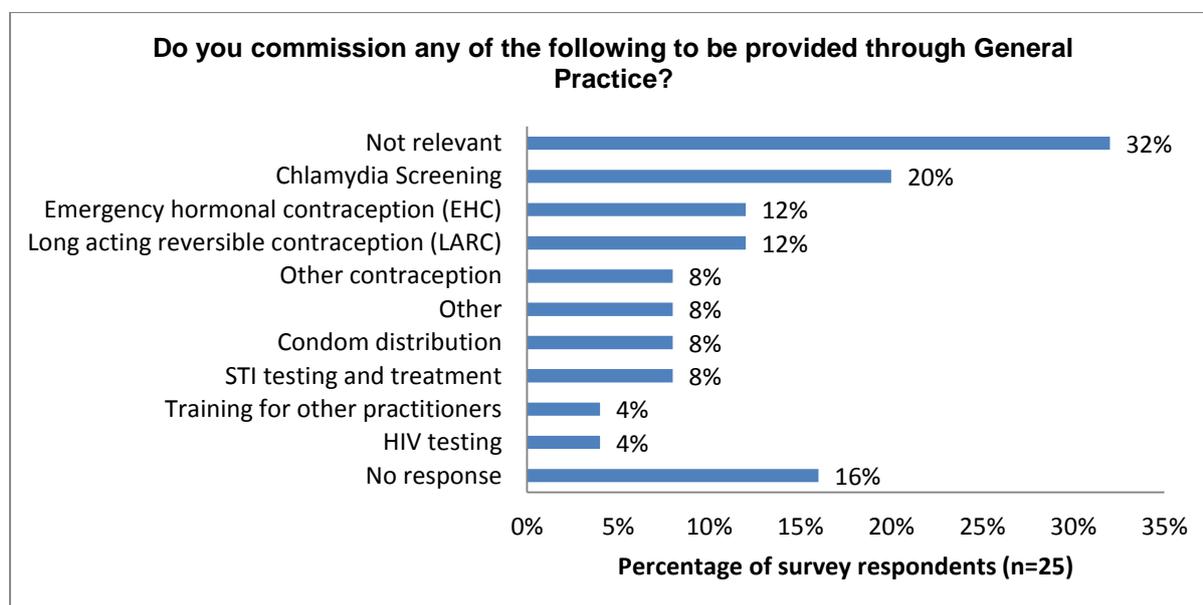
- vulnerable children
- non-English speaking community
- a high university student population that are transient
- arrangements for funding IUD for gynaecology (non- contraceptive) purposes
- black and minority ethnic populations and cultural beliefs in attending STD clinics for contraception

One respondent stated that their “health needs assessment will help to inform the upcoming service specification for integrated sexual health services”.

The London CCGs’ response stated that they “identified hard to reach groups eg co-morbidities, homeless, people without recourse to public funds, complex cases”.

1.3.7 Access to services

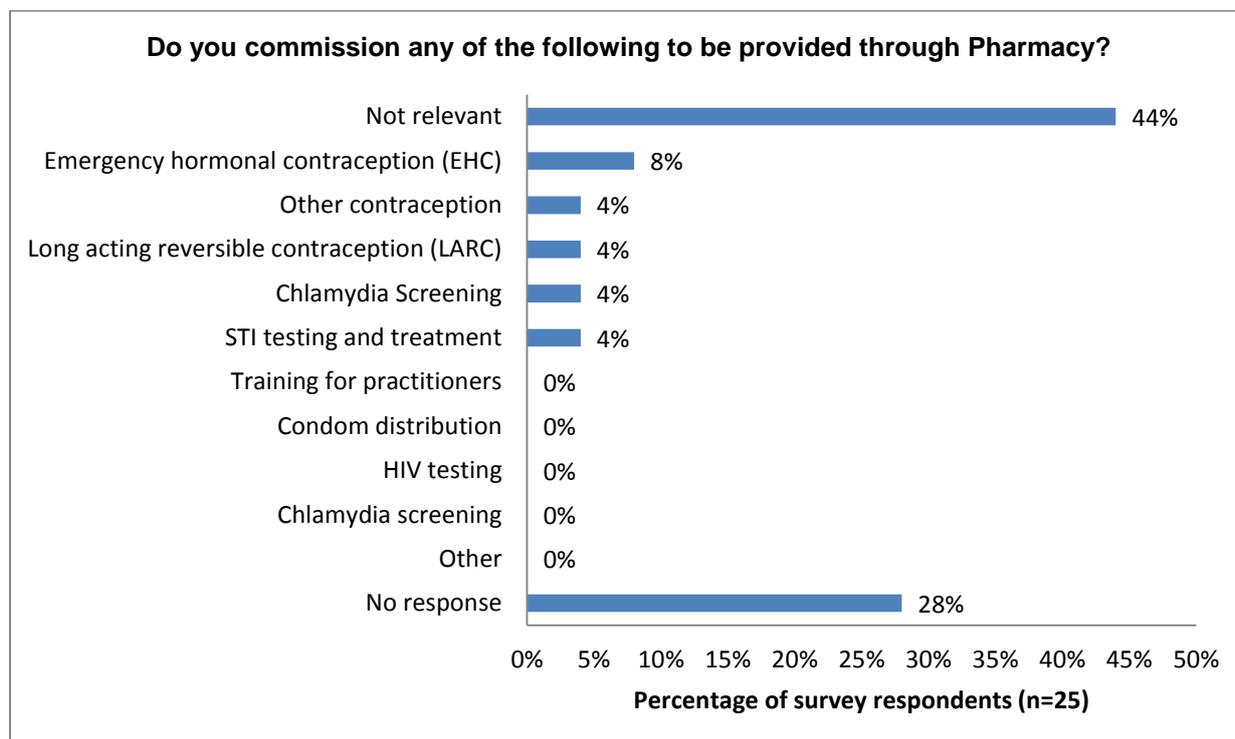
Question 13: Do you commission any of the following to be provided through GENERAL PRACTICE?



CCG respondents could select multiple responses for this question. A third (32%) answered that this was not relevant to them. A fifth (20%) commissioned chlamydia screening through general practice. Three respondents commissioned emergency hormonal contraception and three commissioned LARC through general practice. However, several respondents noted that commissioning of all the options was the responsibility of the local authority public health.

The London CCGs' response selected all the available options but stated that "some CCGs would need to investigate how these are commissioned as this will vary from CCG to CCG".

Question 14: Do you commission any of the following to be provided through PHARMACY?



CCG respondents could select multiple responses for this question. However, over two fifths (44%) responded that this was not relevant to them and over quarter (28%) did not respond to this question. Two respondents commissioned 'emergency hormonal contraception (EHC)' through pharmacy and there was one response each for 'Long acting reversible contraception (LARC)', 'other contraception', 'chlamydia screening' and 'STI testing and treatment'.

The London CCGs' response selected all the available options but stated that "Some CCGs would need to investigate how these are commissioned as this will vary from CCG to CCG".

Question 15: Does your organisation have any concerns about current or future access to sexual health, reproductive health and/or HIV services provided in your area? These could be in Primary Care or in Specialist settings. If so, please provide details.

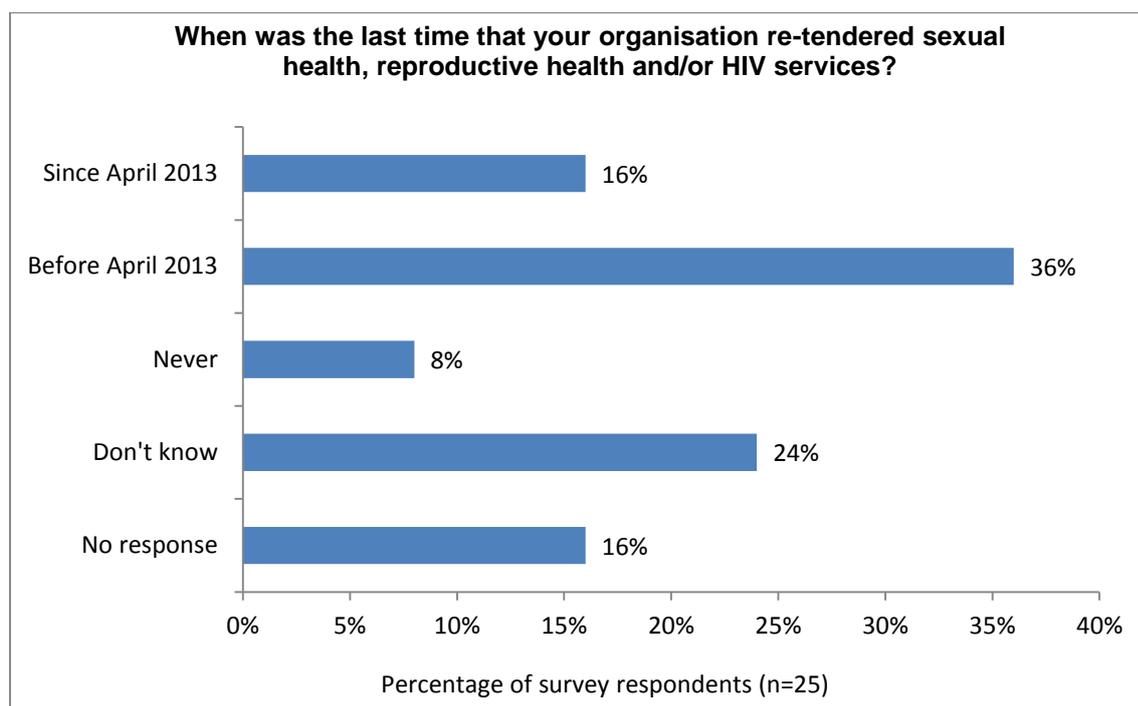
Over half the CCGs (52%) provided a response to this question. A number of concerns were highlighted around the potential impact of financial cuts on service provision and health outcomes. Specific examples included a reduction in services provided, increased waiting times, capping service provision and the lack of provision of services to key risk groups identified in needs assessments. Poor communication between commissioning bodies was also a concern with one

example of a local authority decommissioning cervical screening without informing the CCG.

The response from the London CCGs indicated that ‘fragmentation of services’ and ‘workforce and training issues’ were of specific concern for them.

1.3.8 Tendering

Question 16: When was the last time that your organisation re-tendered sexual health, reproductive health and/or HIV services?

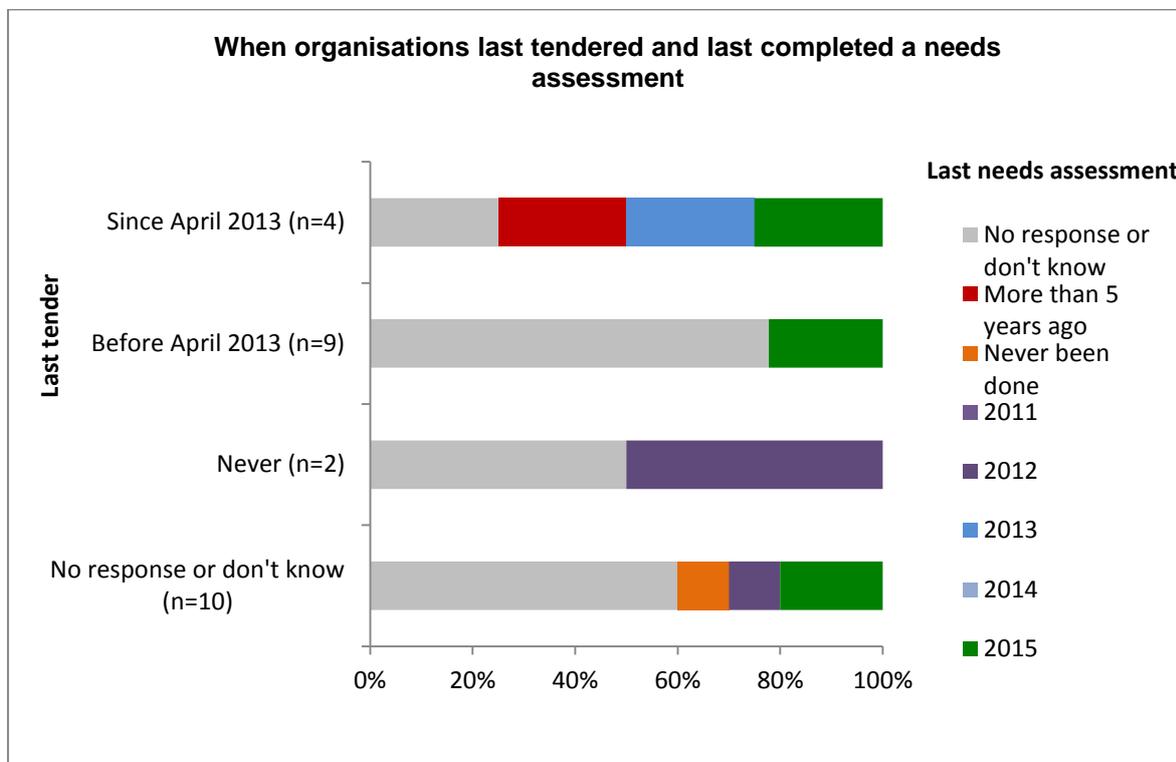


Less than a fifth (16%) of CCG respondents reported that their organisation had undertaken a tender since April 2013. Over a third (36%) noted that services had been re-tendered before April 2013. A quarter (24%) didn't know when services had last been tendered and two respondents reported that their CCG had never tendered services.

A few respondents provided further details, and examples of tenders undertaken since April 2013 included ‘termination of pregnancy services’ and ‘CCG changed pathway to offer telephone based choice’.

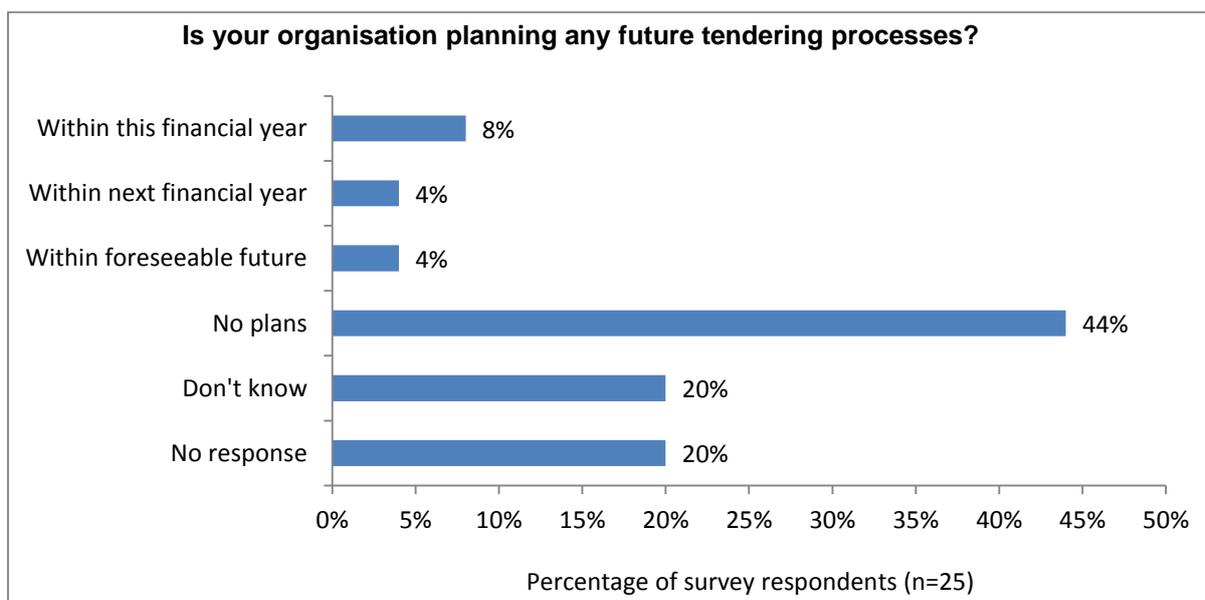
The following chart compares responses to this question with question 8 (In which year was your most recent needs assessment for sexual health, reproductive health and HIV?). Where the last tender took place after April 2013, half the respondents (2 of 4) reported that needs assessments had been undertaken between 2013 and 2015. One had been completed more than 5 years ago and the other provided no

response. Those who had reported needs assessments between 2012 and 2015 had a variety of responses to question 16, a quarter (2 of 8) of which had tendered since April 2013.



The London CCGs reported that their previous re-tendering was before April 2013 and “there are discussions going on at the moment for re-tendering of services”.

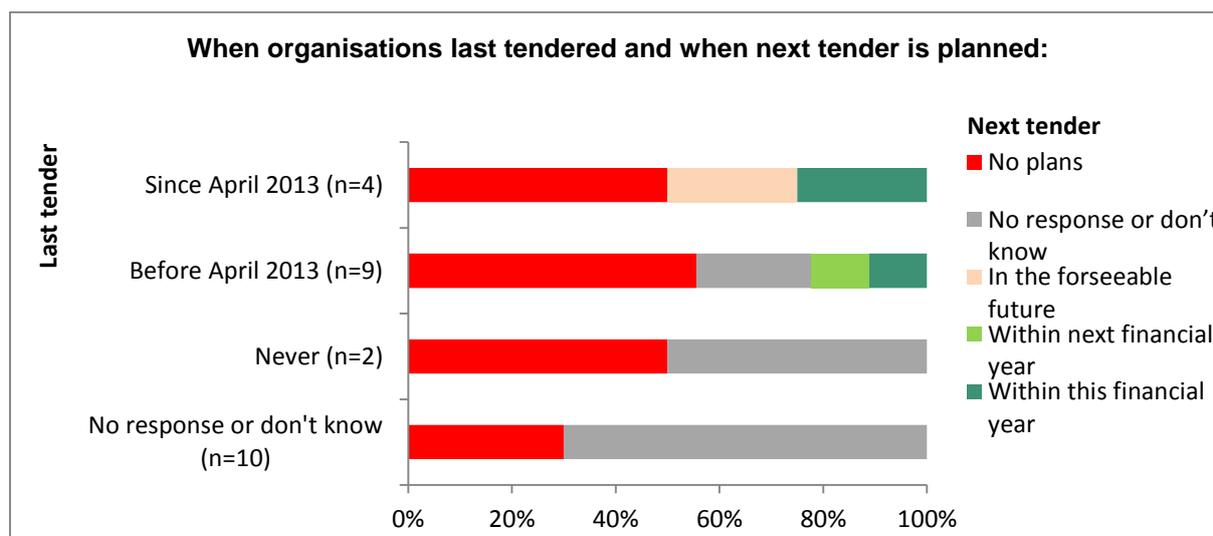
Question 17: Is your organisation planning any future tendering processes?



Two CCG respondents reported that their organisation was planning a tendering process within this financial year and one was planning to tender within the next financial year. In total, less than a fifth (16%) were planning future tendering processes. Further details provided included: “We are currently in the process of undertaking a joint recommissioning exercise with Public Health” and “Re-tendering of TOPs service planned. Fertility service also planned to tender next year.” Over two fifths (44%) had no plans for future tendering. One of these respondents noted “Local authority recently retendered without involving CCG. In the circumstances we will need to use a managed change process until the next local authority procurement”.

Another two fifths (40%) either did not know or did not provide a response to the question.

The following chart shows the comparison between the responses to this question and the previous question regarding when services were last tendered. Where the last tender took place before April 2013, just over a fifth of respondents (2 of 9) were planning a tender in the near future.



The response for the London CCGs stated that they would be planning a re-tendering process within the next financial year.

Question 18: Please describe any issues around commissioning across patient care pathways with commissioners of other parts of the system.

A quarter (24%) of the CCG respondents answered this question. Several issues were highlighted and these are grouped into three main themes:

Difficulty delivering seamless care

Several respondents highlighted difficulties delivering seamless care, for example:

“The **fragmentation of commissioning** responsibilities makes it very hard to develop a seamless care pathway for patients”

Examples of non-streamlined services included ‘HIV and hepatitis and STD clinics’, ‘Mental health-stress and psychosexual counselling’, ‘Termination of pregnancy and interfaces between acute and community services’. One respondent noted that competitive tendering requirements were an obstacle to seamless care: “difficult to integrate Primary Care provision into an overall system when we are forced by Council and NHS procurement rules to have a competitive process”, and also highlighted the role of budget cuts “the impact of public health funding cuts can't be overestimated”.

Joint working

The need for joint working was highlighted: “There needs to be greater joint working across organisations when commissioning new services. Unsure as to the level of engagement with CCGs nationally”. However, another respondent noted that they had a positive experience of joint working: “we work well with local authority colleagues”.

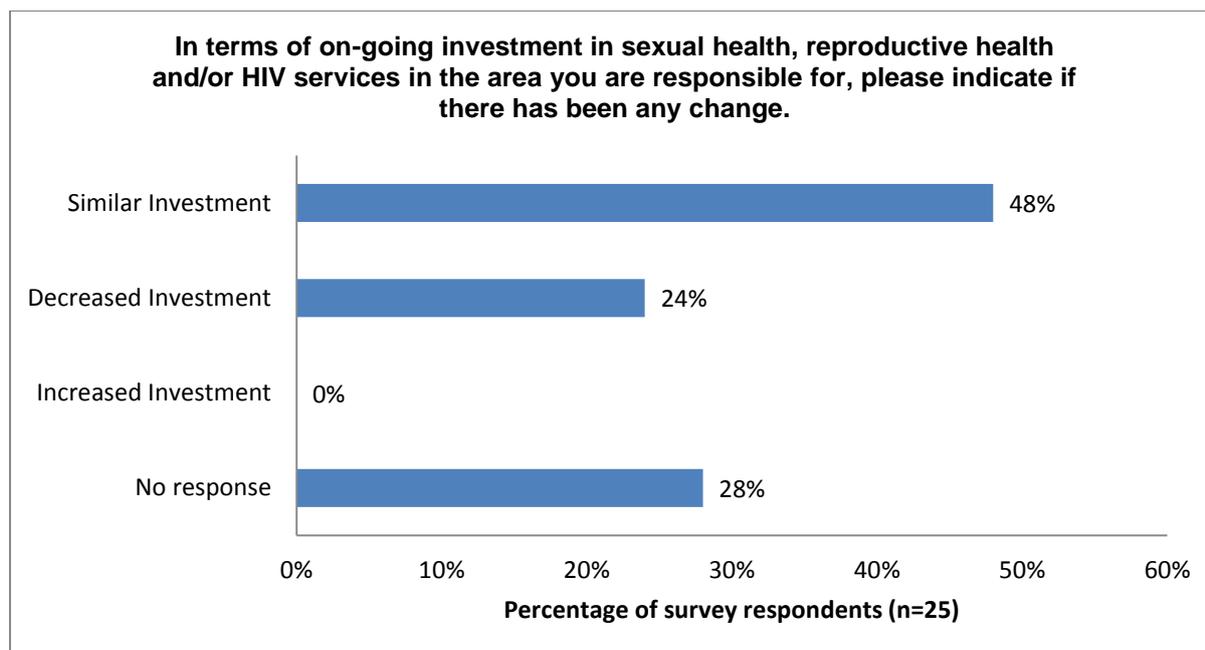
Problems with service quality and meeting population needs

One respondent noted general problems with service quality: “Delivery of services not robust...quality needs to improve”. Another respondent highlighted “long waiting times to access service” and also specific issues in relation to meeting population needs: “No outreach for hard to reach vulnerable groups. No school/college outreach service. Feedback from local Primary Care expresses concerns with their contracts with Public Health to provide CaSH services do not meet the needs of the registered population”.

The London CCGs’ response stated that “London is currently in discussions over a single methodology and/or lead across all London CCGs”.

1.3.9 Re-tendering – changes to investment

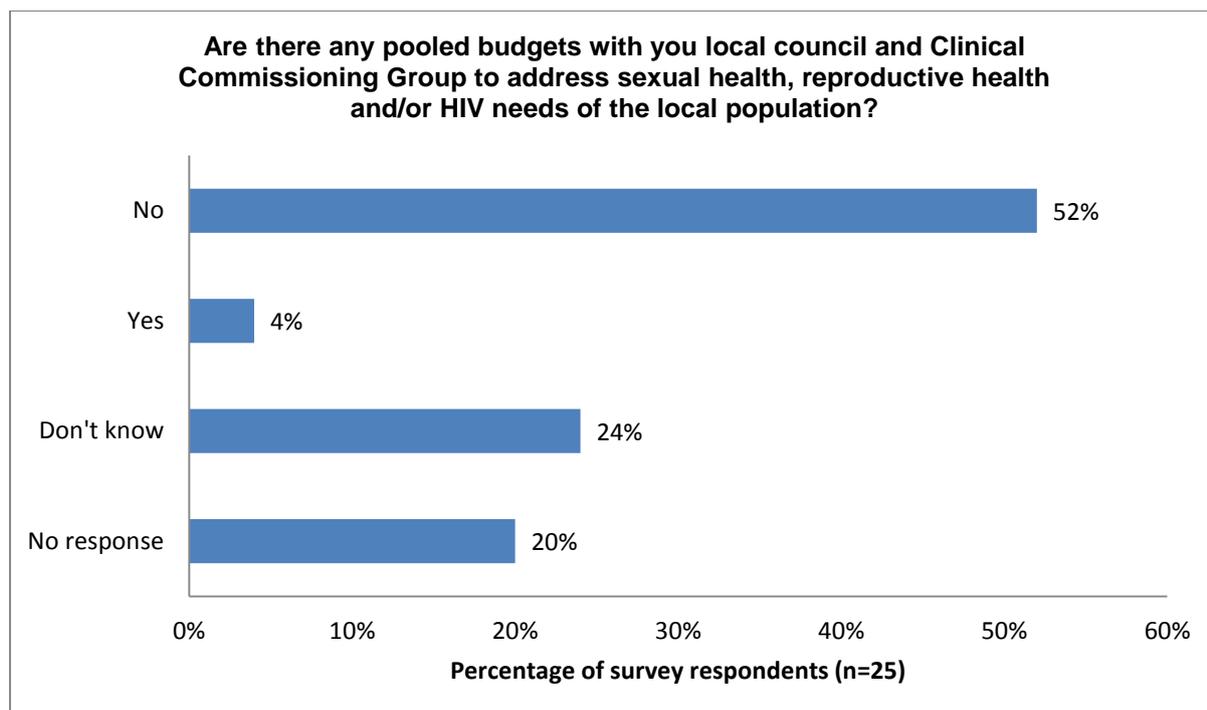
Question 19: In terms of ongoing investment in sexual health, reproductive health and/or HIV services in the area that you are responsible for, please indicate if there has been any change.



Almost half (48%) the CCG respondents reported that there had been no change in investment in SRHH services for which they were responsible. A quarter (24%) indicated that there had been a decreased investment. No respondents reported an increase in investment. However, over a quarter (28%) did not provide a response to this question.

The London CCGs' response reported a similar investment.

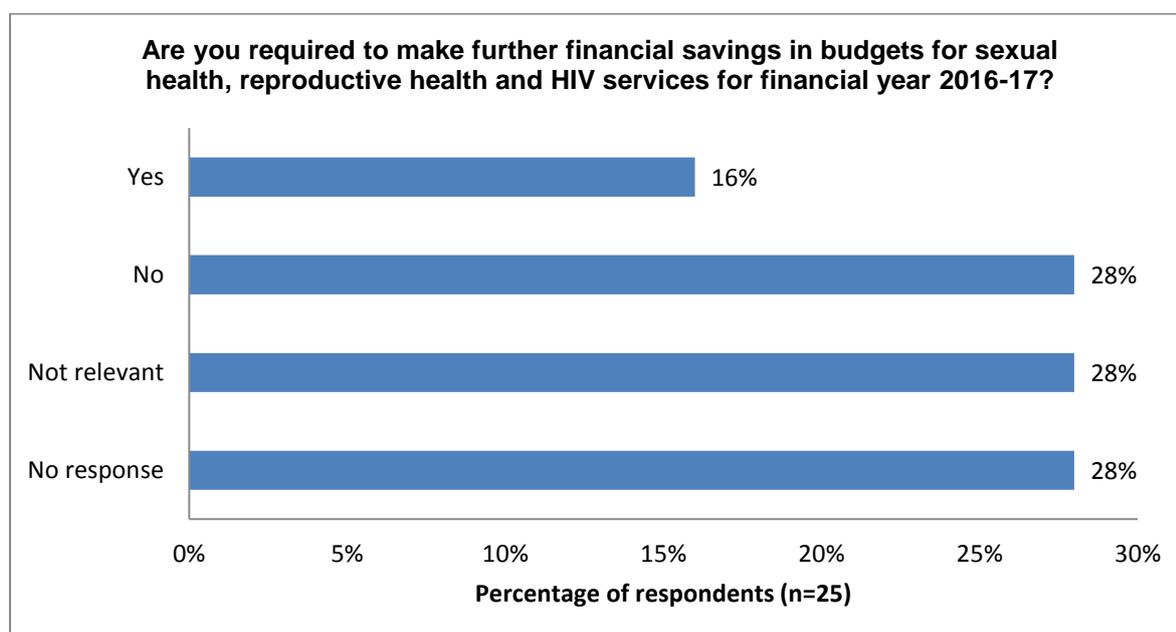
Question 20: Are there any pooled budgets with your local council and clinical commissioning group to address sexual health, reproductive health and/or HIV needs of the local population?



One CCG respondent indicated that pooled budgets existed between the local council and CCG in order to address the sexual and reproductive health and HIV needs of the local population. Three quarters (76%) responded that there were no pooled budgets or that they did not know if these existed.

The London response stated “Don’t know” as the situation was “different across the London patch as some CCGs and LAs have joint commissioning and others don’t”.

Question 21: Are you required to make further financial savings in budgets for sexual health, reproductive health and HIV services for financial year 2016-17?



Under a fifth (16%) of CCG respondents reported that further financial savings in the budgets for SRHH were required. Over a quarter (28%) of respondents were not required to make further savings. Nearly three fifths (56%) indicated that this was not relevant for them or did not provide a response to the question.

The London CCGs' response reported that they were required to make financial savings for the financial year 2016-17.

Question 22: How have you met/will you meet required financial savings in this topic area?

A third (32%) of the CCGs provided a response to this question. These included:

“As this is a relatively small area of activity for the CCG we haven't been benchmarked as a high spender against other areas therefore not targeted for QIPP savings”

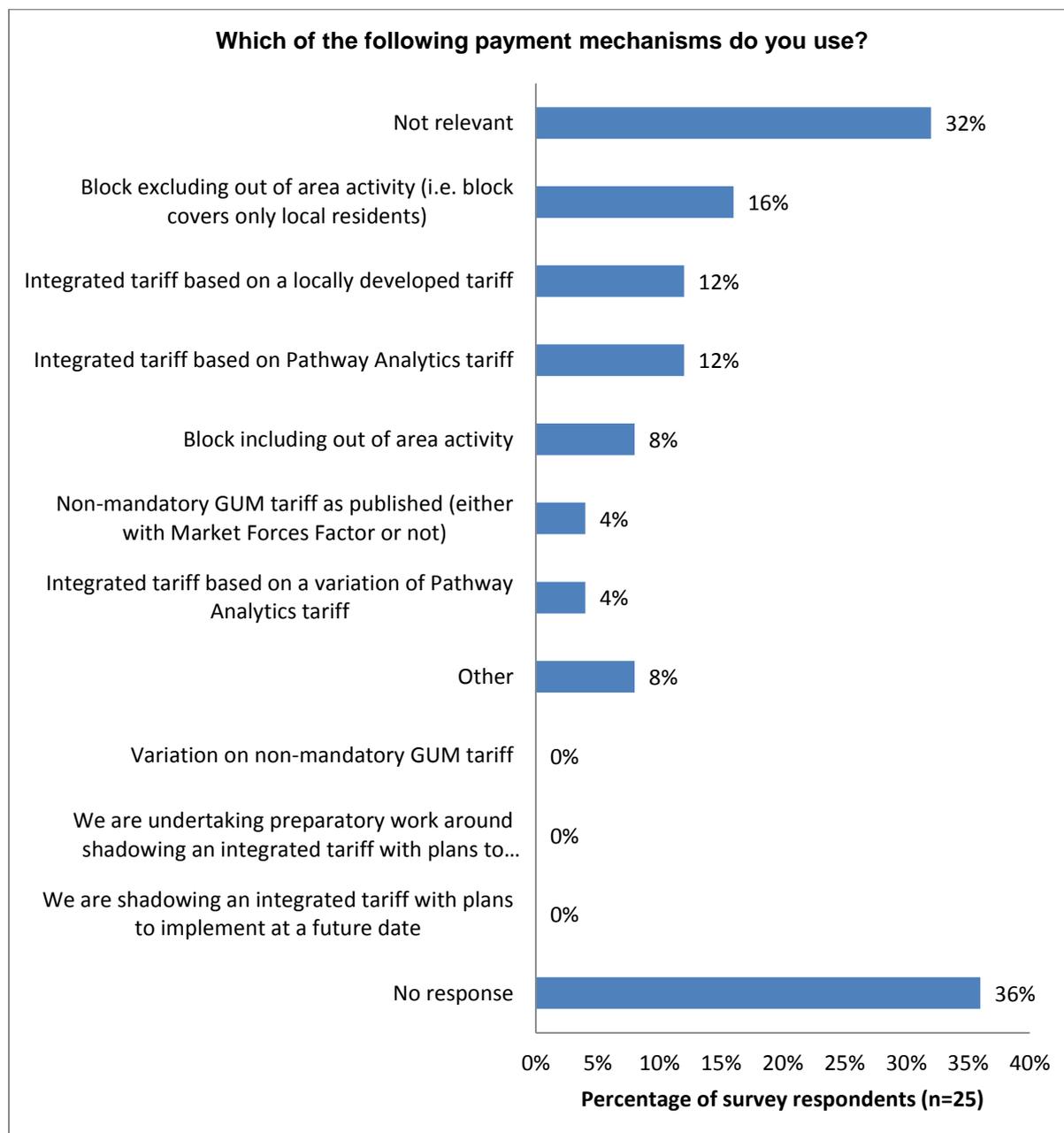
“Block payment - reduced overall spend for termination by prioritising earlier termination and reduction in repeat terminations.”

“CCG is required to develop a financial recovery plan to identify a further £6.5m recurrent savings. Whilst sexual health has not been specifically identified all commissioned services are being reviewed to identify potential cost savings.”

The London CCGs' response simply stated “Yes”.

1.3.10 Tariffs

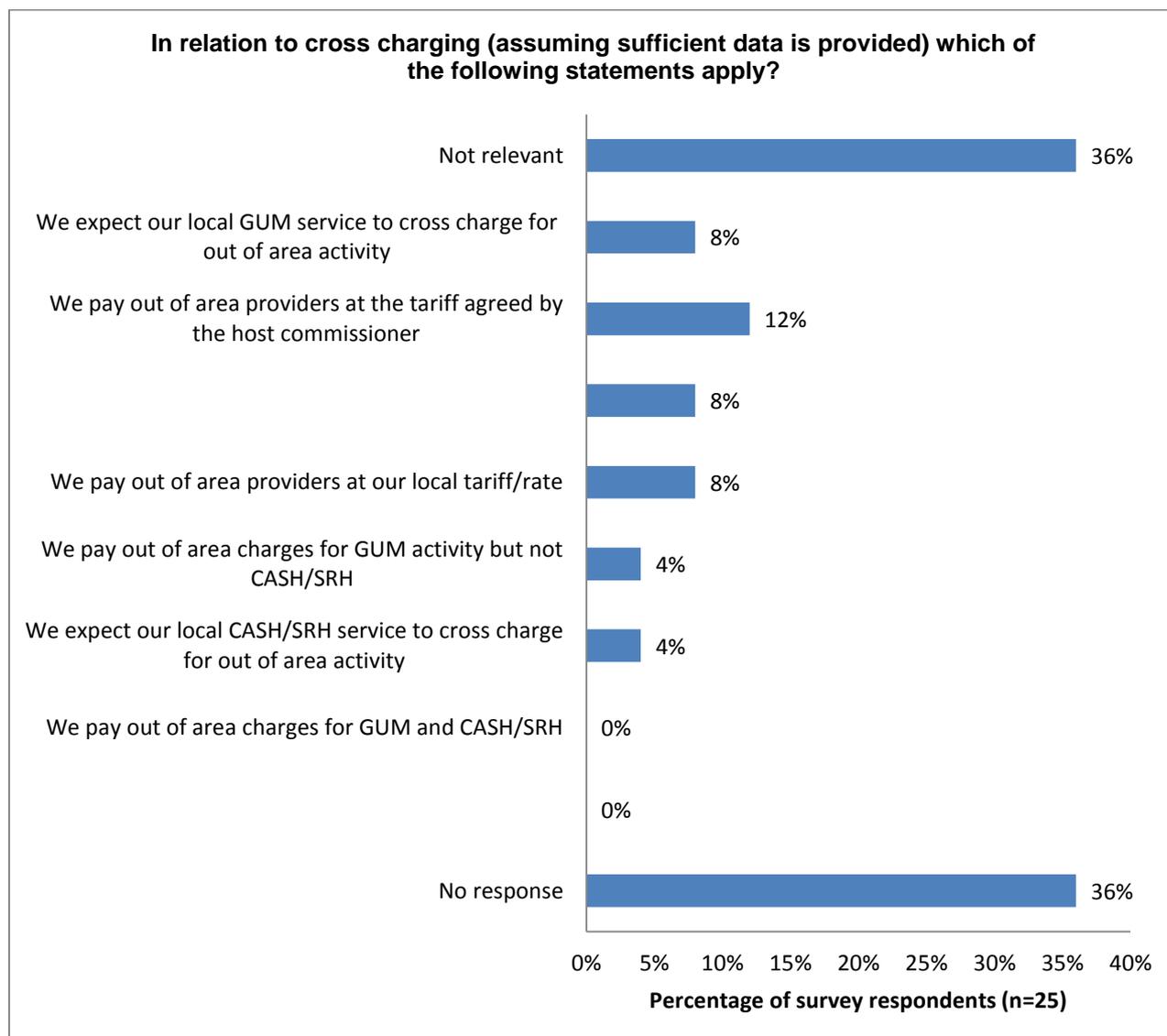
Question 23: Which of the following payment mechanisms do you use?



CCG respondents could select multiple responses for this question. For a third (32%) of respondents, none of the indicated payment mechanisms were relevant to their situation. A further 36% did not respond to this question. Four respondents used a combination of payment mechanisms (range 2 to 5 payment mechanisms). The most frequently used mechanism was 'Block excluding out of area activity'. Locally developed or Pathway Analytics integrated tariffs were each used by 12% of respondents.

The London CCGs' response stated that the payment mechanisms used would vary from CCG to CCG.

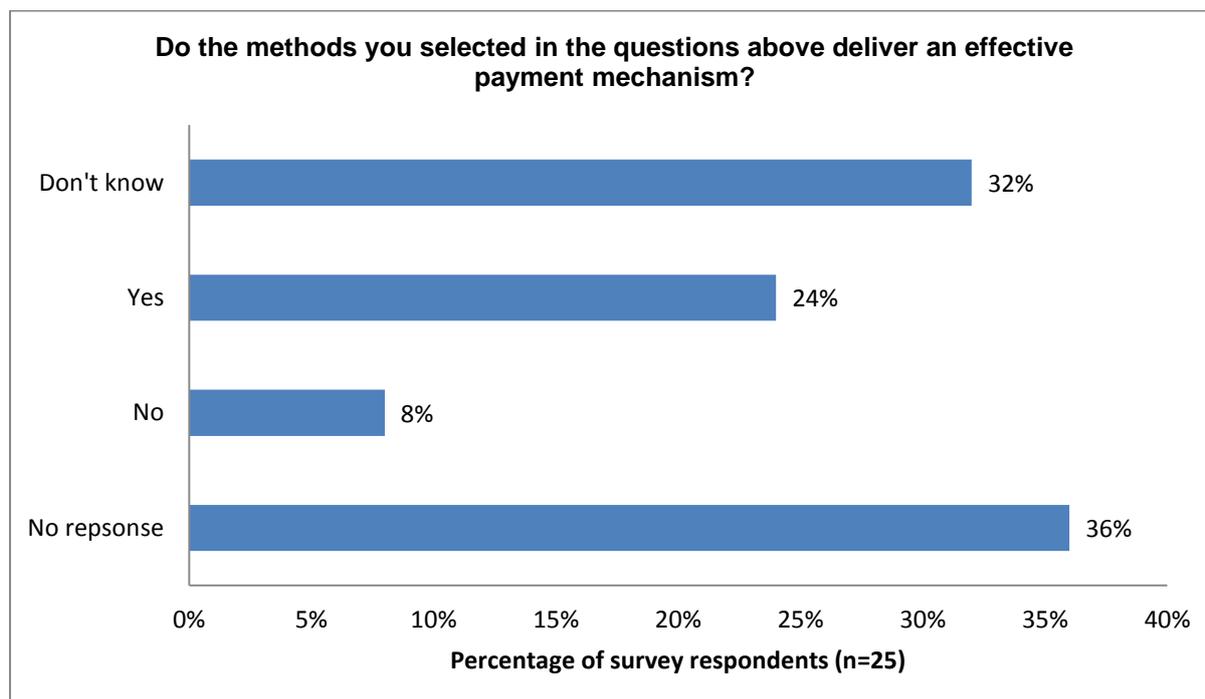
Question 24: In relation to cross-charging (assuming sufficient backing data is provided) which of the following statements apply?



CCG respondents could select multiple responses for this question. More than a third (36%) of respondents indicated that cross charging was not relevant to them, and a further 36% did not respond to this question. Of those who did cross charge, 12% expected this from their GUM service with a further 12% paying out of area providers at the tariff agreed by the host commissioner.

The London CCGs' response stated that this would vary from CCG to CCG.

Question 25: Do the methods you selected in the questions above deliver an effective payment mechanism?

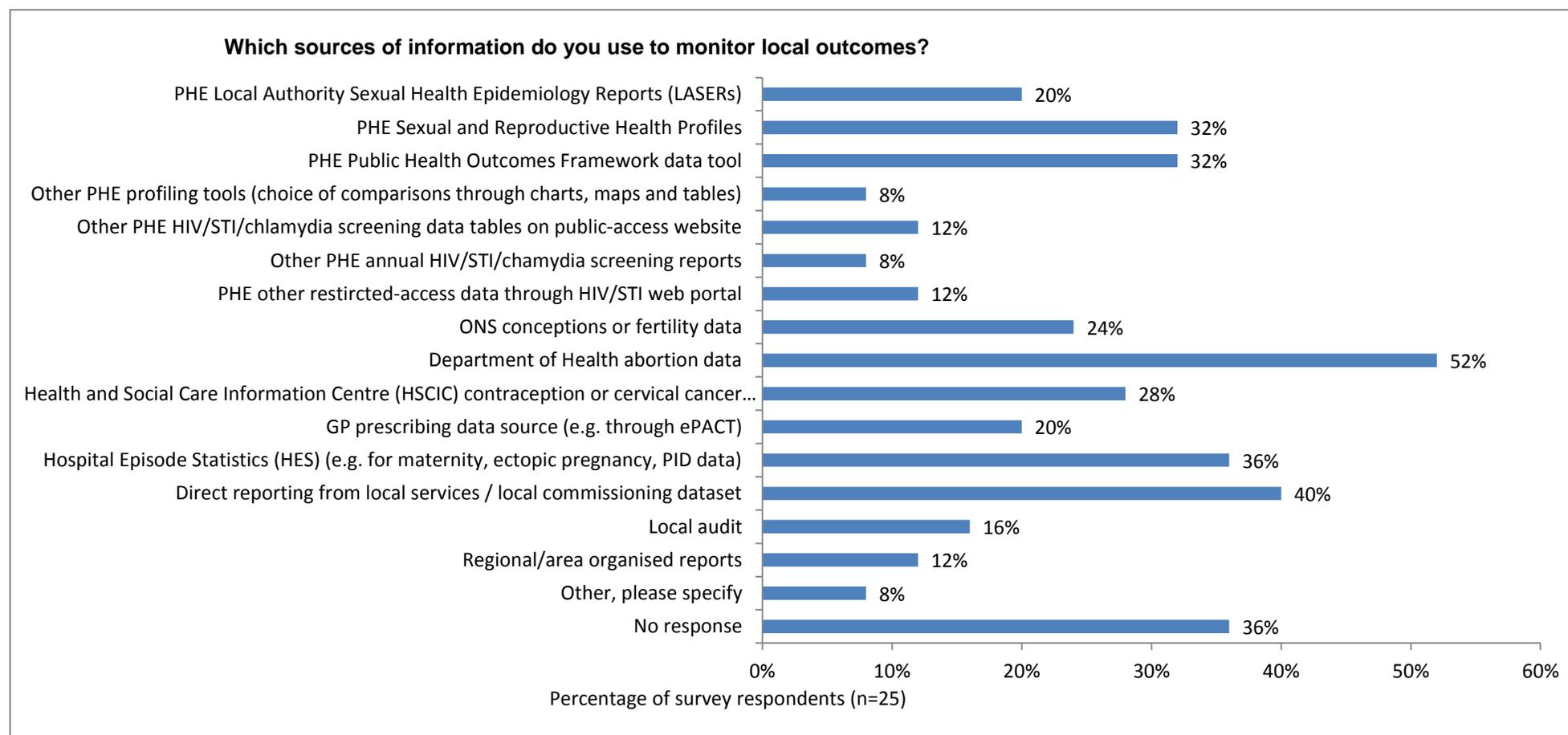


A third (32%) of CCG respondents were not sure if the payment mechanisms and cross charging arrangements delivered an effective payment mechanism, and a further 36% did not respond to this question. However, a quarter (24%) of respondents felt that it was an effective mechanism and only 8% felt that it was not effective.

The London CCGs' response stated that this would vary from CCG to CCG.

1.3.10 Outcomes and performance

Question 26: Which sources of information do you use to monitor local outcomes?

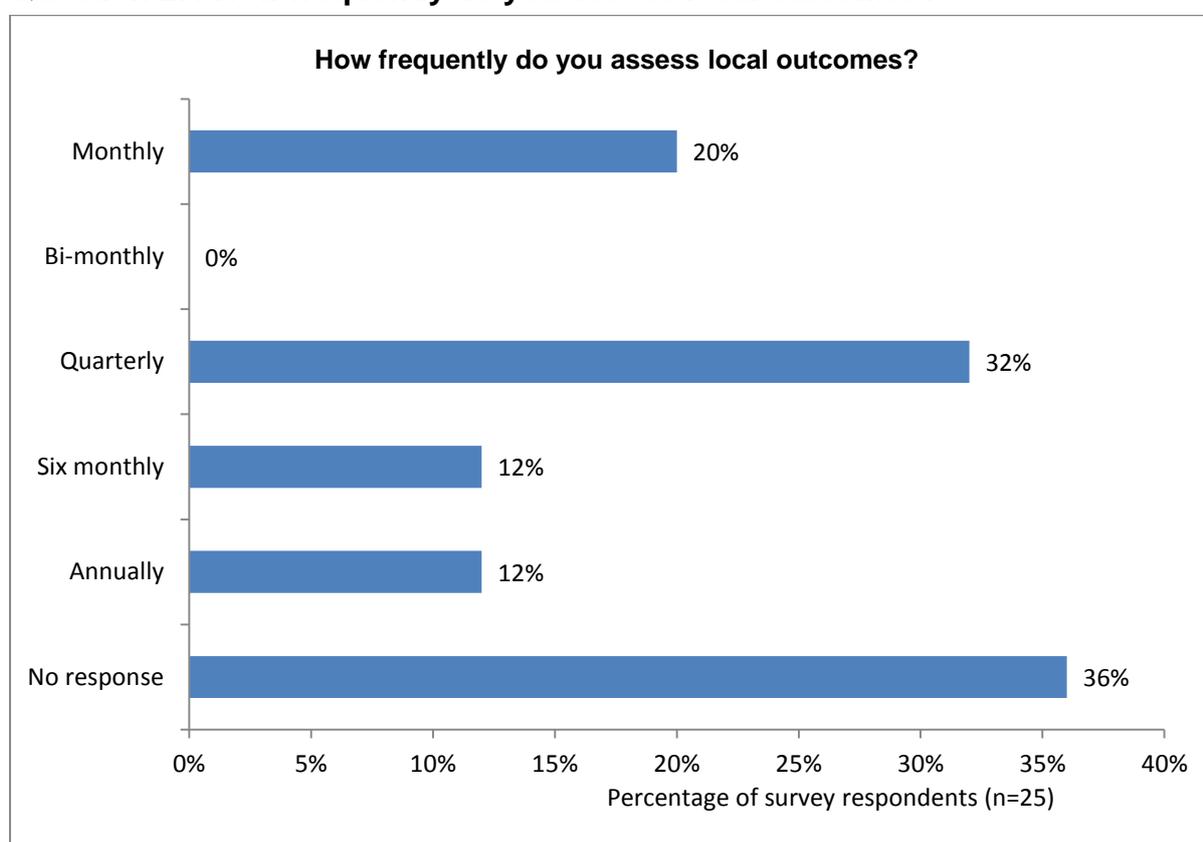


CCG respondents could select multiple responses for this question. The most popular resource was 'Department of Health abortion data', indicated by half (52%) the respondents, followed by 'Direct reporting from local services/local commissioning dataset' (40%), 'Hospital Episode Statistics (HES) (eg for maternity, ectopic pregnancy, PID data)' (36%), 'PHE Sexual and Reproductive Health Profiles' and 'PHE Public Health Outcomes Framework data tool' (32% respectively).

Over a third (36%) of the CCGs left the question blank. Two respondents completed 'Other, please specify'. One stated that local outcomes were not monitored by the CCG, and the other that only terminations were recorded.

The London CCGs' response stated that the sources of information used for monitoring local outcomes would vary from CCG to CCG.

Question 27: How frequently do you assess local outcomes?



CCG respondents were able to select multiple responses for this question, although the majority selected only one.

The most common response was 'Quarterly', indicated by a third (32%) of respondents, followed by 'Monthly' (20%), then 'Six monthly' and 'Annually' (12% respectively). However, over a third (36%) of respondents left this question blank.

There was a further response, 'Other, please specify', which was completed by two respondents. One stated that they do not monitor local outcomes as a CCG and the other stated that the only local outcome assessed was terminations.

London CCGs assess local outcomes on a quarterly basis.

Question 28: What is your internal mechanism for reporting local outcomes?

Nearly half (48%) of the CCG respondents answered this question, one of which stated that there were no internal mechanisms for reporting.

Although there were elements of overlap, the responses fell into three main categories: 'Contract', 'Performance management' and 'Reporting to a board'.

Contract

This could be through a contract monitoring mechanism or reporting to a contract review or management board. Respondents also stated that service user feedback, including complaints and compliments, was used. Serious incident and quality issue reporting were also used to monitor local outcomes.

Performance management

Respondents mentioned service quality meetings, provider management and quality teams, and quarterly performance meetings (including a CCG quality group).

Reporting to a Board

In the final category, respondents stated that reporting to a board was a mechanism for reporting their local outcomes. Specific groups or boards that were mentioned included finance and performance committee, relevant programme board, CCG board, clinical commissioning committee and a joint commissioning board between CCG and the local authority.

The London CCG response stated that this would vary between CCGs.

Question 29: If outcomes are poor, how is this managed?

Over half (52%) the CCG respondents answered this question. Management of poor outcomes fell into a variety of categories:

Contractual mechanisms, meetings or management

This varied from discussion with providers, additional clinical input, monitoring mechanisms to termination contract meetings and a contract review board.

Performance management, quality review

This could be clinical quality review meetings, or performance indicators. Quality review groups with providers were also mentioned by respondents and finally, provider management and quality teams.

Remedial action plans

Internal CCG mechanisms

These included internal CCG committees, or it was managed internally with provider or escalated to CCG executive team if required.

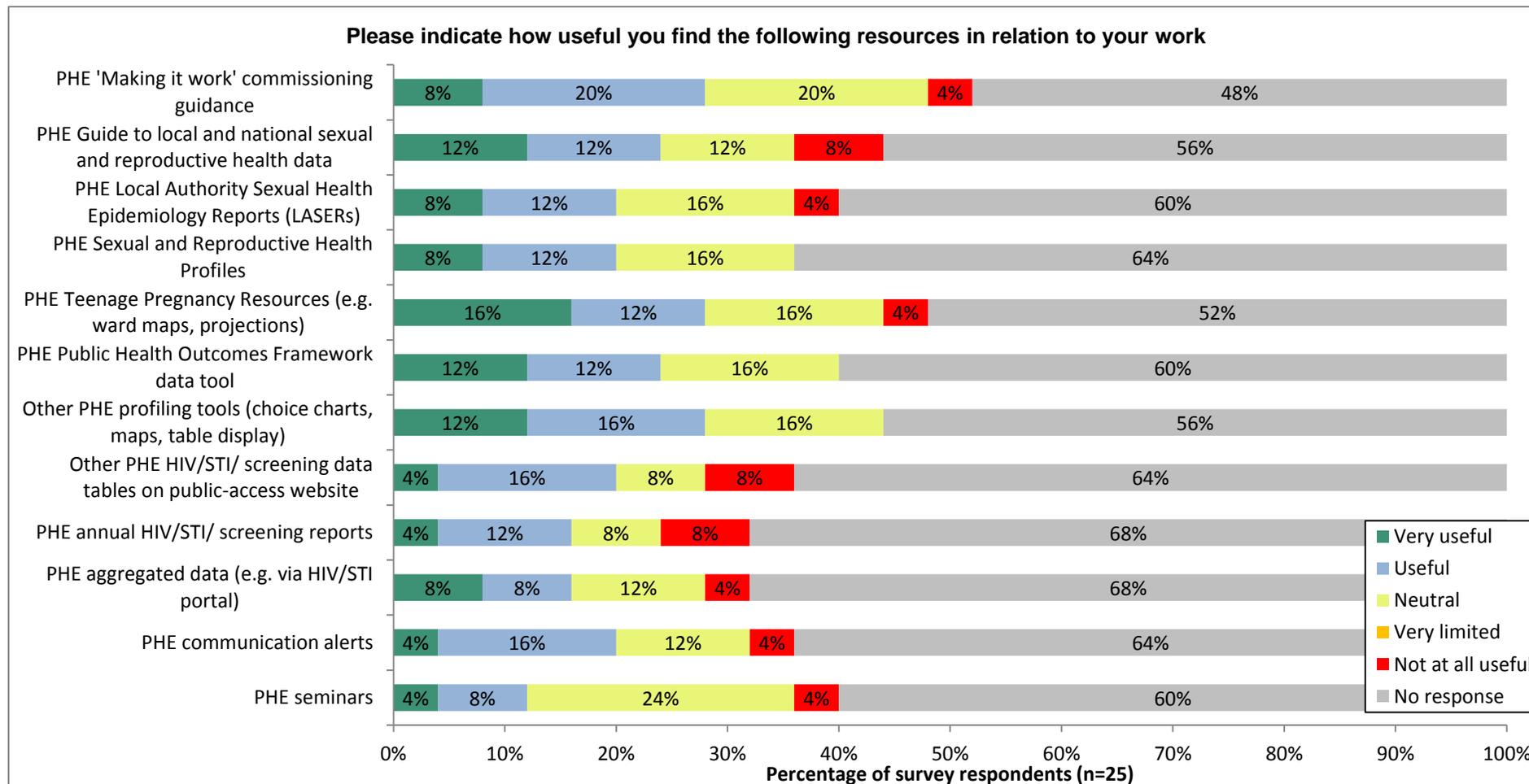
Working with local authorities

This included working with local authority commissioners to ensure a joint approach, putting additional reporting mechanisms in place or working jointly across both the CCG and local authority. Respondents also stated that the management of poor outcomes was the responsibility of the local authority.

The London CCGs' response stated that this would vary from CCG to CCG.

1.3.11 PHE Resources

Question 30: Please indicate how useful you find the following resources in relation to your work.



'PHE Teenage Pregnancy Resources' had the highest proportion, 16%, of CCG respondents indicating that they were 'very useful'. This was followed by 'Other PHE profiling tools', 'PHE Public Health Outcomes Framework data tool' and 'PHE Guide to local and national sexual and reproductive health data', where 12% respondents stated that they were 'Very useful'. 8% of responses (n=2 of 25) stated that the following resources were 'Not at all useful': 'PHE annual HIV/STI/screening reports'; 'Other PHE HIV/STI/screening data tables on public-access website' and 'PHE Guide to local and national sexual reproductive health data'. All resources were rated as 'Useful' or 'Very useful' by at least 12% of respondents.

The London CCGs' response stated that all of these resources were 'Neutral' in relation to their work.

Question 31: What other help or support would you like from PHE?

There were five CCG responses to this question. One response stated that they would like no further help or support from PHE. Other responses specified that they would like help or support to understand the resources available for CCGs from PHE, further support for Primary Care and outreach services to schools and colleges, health inequality data, and support reconnecting health with public health - so that burden on health services is reduced.

The London CCGs' response stated that they would like: "Intelligence support - source of robust statistical and analytical information" and "Some formal consultation and patient engagement support".

1.3.12 Top challenges

Question 32: Do you have any examples of good practice that you would be willing to share?

Only the London CCGs' response provided an example of good practice: "London has a Pan-London abortion service group that meet quarterly to share good practice and knowledge, with recent DH involvement."

Question 33: What are the top three challenges that you face when commissioning sexual health, reproductive health and HIV (this could include risk areas or areas of concern)?

Over a third (36%) of the CCG respondents answered this question and various challenges were highlighted. Two key themes were:

Fragmentation of commissioning

The majority of respondents highlighted challenges dealing with fragmentation of the commissioning system, such as commissioning of long-acting reversible contraception "separation of commissioning responsibility for medical/contraceptive coils", and

confusion/conflicts that can arise, for example: “confusion within General Practice as to which organisation commissions which elements of sexual health”. One respondent also noted the resulting “lack of clinical engagement into commissioning/monitoring services”.

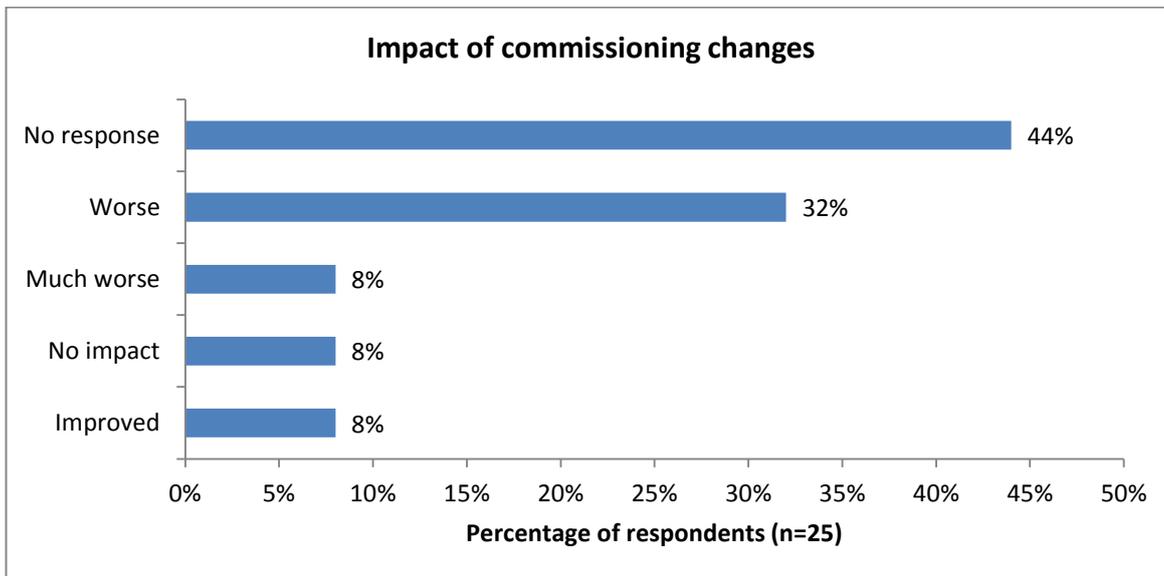
Budget cuts/constraints

Several respondents also highlighted issues with budget cuts/funding, for example: “Impact of public health cuts on CCG provision”. Examples of the impact of this were “service quality within a reduced envelope” and “maintaining a focus on prevention due to resource constraints”.

Other issues highlighted by individual respondents included “safeguarding”, “ensuring that you can identify repeat attenders”, “developing the provider market”, “marketing and communication of services”, “cross boundary working”, “access to abortion services for late gestation women and/or women with pre-existing medical complications unable to receive treatment in a community setting”.

The London CCGs’ response reported that challenges were the profile of sexual health within the CCG – “As these tend to be small services - profile is an issue” - and the need for “a more coherent sexual health strategy including a cradle to death type of approach.”

Question 34: What impact have the commissioning changes introduced in April 2013 had on the sexual health, reproductive health and HIV system in your local area?



Two fifths (40%) of the CCG respondents indicated that the commissioning changes in April 2013 had had a worse or much worse impact on the local HSRH commissioning system. Just 8% (n=2) indicated that the system had improved. A third (32%) provided no feedback for this question.

Six respondents provided further details for this question. For those viewing the changes as worse/much worse, the following key themes were highlighted:

Fragmentation and confusion, for example “Confusion and disjointed commissioning of services”

Disinvestment and reduced services, for example: “reduced clinics, reduced staffing, no longer provider wider women’s health service cervical screening obsessed with hitting chlamydia screening targets, outreach work reduced”

One respondent also noted **lack of CCG time and expertise**: “It’s particularly hard in CCGs as we have so few services left that it doesn’t fit neatly into anyone’s job. The person who gets landed with it has to fit it in on top of a day job but quite often without any support or expertise.’ One of the respondents who noted that services had improved still provided a mixed picture: ‘Teenage pregnancy rates have decreased, however STI rates have increased”.

The London CCGs’ response indicated that the commissioning changes had had a ‘Worse’ impact and “There is now a perception that services are much more fragmented”.

1.3.13 Further comments

Question 35: If you have any further comments, please elaborate in the space below:

Three respondents provided further comments. One questioned the relevance of some of the question to CCGs in terms of the listed services. The other two respondents emphasised concerns regarding the impact of the commissioning changes (including one who had not provided further comment for the previous question) in terms of loss of expertise:

“We had a well commissioned local service run by GPs with an interest in sexual health working as private providers, we have lost this expertise and trusted care through the 2013 changes, would be good to try and get some of this resource back for local populations”

“Are local authorities best placed to commission sexual health services - how do they ensure clinical input?”

The London CCGs’ response noted that: “This survey has been completed for London as a whole and therefore is not specific to any one CCG. There were many questions where it was impossible to give a definitive answer as will vary from CCG to CCG”.

Appendix 2: Action Plan

SEXUAL HEALTH REPRODUCTIVE HEALTH AND HIV COMMISSIONING ACTION PLAN

Actions	Key Deliverables
<p>1. Reduce fragmentation of commissioning and resolve contracting systems barriers</p>	<p>1.1 Develop a model of lead commissioning in conjunction with commissioning organisations, ADPH, LGA, DH and NHS Clinical Commissioners that:</p> <ul style="list-style-type: none"> • reviews service user flows and identifies patterns of service usage to support local commissioning • ensures appropriate data provision is specified in relevant contracts • identifies system leaders across the country to lead local sexual health, reproductive health and HIV commissioning within an agreed locality and to form a national network of commissioning leads to promote effective national development of commissioning • reviews the current contracting model with ADPH and DH with the view to support and develop key areas of contracting including: <ul style="list-style-type: none"> - development of local tariff - out of area cross-charging agreements at local level - models of integrated service delivery - models of effective NHS England and CCG involvement <p>1.2 Tests a model of local delivery based on examples of local practice to assist in the effective commissioning of sexual health, reproductive health and HIV</p>
<p>2. Support Commissioners in delivery of effective</p>	<p>2.1 Building on the existing guidance, produce a more focused aid to commissioning that:</p> <ul style="list-style-type: none"> • explicitly addresses the key issues from the survey

Actions	Key Deliverables
<p>commissioning</p>	<ul style="list-style-type: none"> • provides advice and examples of locally designed system solutions to support commissioning of sexual health, reproductive health & HIV services • provide a single reference document that brings together a wide range of resources to assist commissioners in delivery of each step in the commissioning cycle • provides case studies and reference material that describes actual experience from across the country <p>2.2 Integrated sexual health specification/termination of pregnancy specification:</p> <ul style="list-style-type: none"> • develop updated Integrated Sexual Health Services AND Termination Services specifications (on behalf of the Department of Health) in conjunction with key stakeholders. These will include ways that NHS and LG commissioners work together to commission joined up services.
<p>3. Building capacity and capability in sexual health commissioning</p>	<p>3.1 Facilitate and support sexual health, reproductive health & HIV networks operating across the country:</p> <ul style="list-style-type: none"> • map and promote existing commissioner networks • review footprint of networks to ensure optimal coverage • utilise the LGA Knowledge Hub (KHub) as a focal point for the sharing of resources for networks <p>3.2 Facilitate discussions, both local and nationally, to ensure the development of an effective provider workforce.</p> <p>3.3 Agree a work programme with Health Education England and the Faculty of Reproductive and Sexual Health and British Association of Sexual Health and HIV:</p> <ul style="list-style-type: none"> • undertake local audits, identify gaps and produce plans to address identified needs <p>3.4 Develop, in conjunction with LGA and ADPH, a framework for sector/system lead improvement activity</p>

Actions	Key Deliverables
	<p>for sexual health, reproductive health and HIV that is explicit in how LG led Sector led Improvement interfaces with the NHS Improvement systems.</p> <p>3.5 Update service specification and commissioning guidance to improve the quality and effectiveness of abortion services.</p>
<p>4. Provide evidence and data to commissioners to support commissioning and the monitoring of outcomes</p>	<p>4.1 Continue to provide and develop a suite of information and data tools to support commissioners and service providers including:</p> <ul style="list-style-type: none"> • Sexual Health Profiles • LASERS • web portal information <p>4.2 Utilise information to provide open and transparent information on sexual health, reproductive health and HIV.</p> <p>4.3 Organise events, workshops and training for commissioners so they have access to the best available evidence, research and information to inform their commissioning decisions.</p> <p>4.4 Support commissioners to review and evaluate services and ensure wide dissemination of these results.</p> <p>4.5 Produce customised briefings to support commissioners in making the case for investment in sexual health, reproductive health and HIV services, covering:</p> <ul style="list-style-type: none"> • return on investment from preventative measures • impact on place of effective sexual health, reproductive health and HIV provision • a suite of topic specific briefings to provide key information to inform commissioning, eg MSM, PrEP, Reproductive Health.
<p>5. Ensure that</p>	

Actions	Key Deliverables
<p>sexual health, reproductive health and HIV commissioning is explicitly considered within the changes in the system and mechanisms for public health funding from local government funding over the next three years</p>	<p>5.1 As part of wider work on public health funding, post ring-fence, ensure that the new model is able to respond to the sexual health needs of local areas. Work to include:</p> <ul style="list-style-type: none"> • a review of mandate • involvement in new systems of funding as they develop