



Public Health
England

Making it work

A guide to whole system
commissioning for sexual and
reproductive health and HIV

FINAL DRAFT

This draft is being made available on the Gov.uk [website](#) from Friday 23 May – Thursday 12 June to allow stakeholders an opportunity to respond on a final set of specified questions.

PHE Gateway: 2014-090

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Executive summary

Pending

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Key messages

1. Put people at the centre of commissioning, which is based on assessed needs rather than current service configuration.
2. Take service user pathways as your starting point, with the aim of ensuring they experience integrated, responsive services.
3. Maximise opportunities to tackle the wider determinants of health.
4. Build on your director of public health's (DsPH) role to deliver system stability and integration across the public sector.
5. Draw on the expertise of clinicians and service users, and the public's views, to inform commissioning.
6. Build trust across commissioning organisations by developing strong relationships with your local counterparts.
7. Collaborate - a larger commissioning footprint will make the best use of limited resources to improve outcomes.
8. Document your approach to collaborative working, with clearly defined individual and collective responsibilities.
9. Acknowledge the economic climate requires new thinking and innovation – doing more or less of the same will not radically change outcomes or provide better value.
10. There is no one right way – it is up to local teams to make collaborative sexual and reproductive health (SRH) and HIV commissioning a local reality.

Section 1. Purpose of this document

- 1.1. This guide is for commissioners of sexual and reproductive health (SRH) and HIV services in local government, clinical commissioning groups (CCGs) and NHS England.
- 1.2. It has been developed to support commissioning bodies to deliver high quality SRH and HIV services, in line with their responsibilities set out in the Health and Social Care Act 2012.
- 1.3. The health and social care reforms represent a significant change in commissioning arrangements. As with any change, this presents challenges for learning how the new arrangements work, and developing relationships with new players or existing organisations with new roles to deliver the best outcomes. The change also represents an opportunity to re-evaluate what is needed, and how this can best be delivered in an environment of limited resources. This involves both building on past success and challenging ourselves to ensure we are delivering the most effective and relevant services to meet the needs of our populations now and into the future.
- 1.4. This guide looks at how to pull the whole commissioning system together, with a focus on two key areas:

Interfaces in commissioning responsibility detailing the areas where more than one commissioning organisation is responsible for different elements of care that an individual may need. It articulates how commissioning bodies need to work together to ensure that the individual experiences seamless delivery of services to meet their needs.

Addressing the wider determinants of health – illustrating examples of local areas taking a wider view to address an area of need. By considering the wider influencing factors, local areas are able to tackle the causes rather than just the symptoms, and really begin to make a difference to the health of their local populations.
- 1.5. It is not intended as a general guide to ‘how to commission services’; nor does it specify what services need to be commissioned, which needs to be based on an assessment of local need. There exists an extensive range of information on these elements and this guide should be read in conjunction with these other documents (see Annex 1).

1.6. This guide will:

- provide clarity on commissioning responsibilities across the system [Section 2]
- make the case for whole system commissioning – illustrating why it matters for the individual and the population; and why it makes sense for commissioners and providers in terms of efficient use of resources [Section 3]
- describe the levers and mechanisms available in the system to enable and support whole system commissioning [Section 4]
- identify how commissioners can work together collaboratively to deliver improved outcomes for service users and populations, demonstrating relevant and practical tools to deliver a whole system approach [Section 5]
- suggest how best to commission services that make sense to the user where more than one commissioning body is responsible [Section 6]
- provide information on, and links to, other key documents to support commissioners [Annexes 1, 2, 3]
- provide an overview of NHS England structures and responsibilities for sexual and reproductive health and HIV commissioning [Annex 4]
- provide an overview of Public Health England structures [Annex 5]
- demonstrate the importance of taking a population focus when managing infectious diseases [Annex 6]
- demonstrate models of existing and emerging local practice to illustrate how commissioners are working collaboratively to best meet the needs of their local populations and address health inequalities [throughout the document]

Section 2. Who does what? Responsibilities for commissioning SRH health and HIV

2.1. This section:

- outlines the commissioning responsibilities of local government, CCGs and NHS England for SRH and HIV services
- describes the principles underpinning the commissioning responsibilities

2.2. The commissioning responsibilities of local government, CCGs and NHS England are enshrined in the Health and Social Care Act 2012.¹ Local government responsibilities for commissioning most sexual health services and interventions are further detailed in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.² These mandate local authorities to commission confidential, open access services for STIs and contraception as well as reasonable access to all methods of contraception. NHS England is responsible for commissioning healthcare services provided as part of GP contracts, whether General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS), including sexual health services provided under these contracts.

2.3. Since April 2013, commissioning for sexual and reproductive health and HIV has been organised as outlined in Figure 1 below.

2.4. General principles which underpin these arrangements are as follows:

2.4.1. Where a commissioning body is responsible for an area of care, they have to meet all the costs in a number of contexts. For example, except in the context of the core GP contract, local government is responsible for STI testing in any setting, including in abortion services (with CCGs having commissioning responsibility for the abortion service)

2.4.2. Where a commissioning body is responsible for an area of care, they are responsible for all the costs related to the provision of that service. For example, local authorities commissioning provision of long acting reversible contraception (LARC) from general practice are responsible for the costs of the LARC devices and prescriptions.

¹ Health and Social Care Act 2012, <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217032/local-authority-charging-for-public-health-activity.pdf

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Figure 1. Commissioning arrangements from April 2013

Local authorities commission	Clinical Commissioning Groups Commission	NHS England commissions
Comprehensive sexual health services. These include:	Most abortion services. (See 'specialist foetal. medicine' services)	Contraceptive services provided as an 'additional service' under GP contracts *
1. Contraception (including the costs of LARC devices and prescription or supply of other methods) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care under local public health contracts (such as arrangements formerly covered by LESs and NESs)	Female sterilisation	HIV treatment and care including cost of all Anti-Retroviral Treatment
2. Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) HIV testing, and partner notification for STIs and HIV	Vasectomy	Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients. (ie not part of the public health commissioned services, but relating to the individual's care)
3. Sexual health aspects of psychosexual counselling	Non-sexual health elements of psychosexual health services	All sexual health elements of healthcare in the justice system including HIV
4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies	Gynaecology, including any use of contraception solely for non-contraceptive purposes (except when provided in general practice – see column to the right)	All sexual health elements of healthcare for armed forces and their families including HIV
	HIV testing, including routine screening, in non-HIV hospital departments	Sexual assault referral centres (open access one-stop service to help victims of rape or sexual assault)

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		Cervical screening in a range of settings
Related social care services (funding sits outside the Public Health ring fenced grant and responsibility for these services lay with local authorities prior to April 2013:		HPV immunisation programme
- HIV social care		Specialist foetal medicine services, including late surgical termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks
- Wider support for teenage parents		NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, Hepatitis B
		Contraception provided solely for non-contraceptive purposes in general practice

2.5. Local authorities are also responsible for commissioning a number of other services, such as social care, family support, education, and housing, which can have a close link to public health, including sexual health. Likewise, NHS England and CCGs have other commissioning responsibilities that link closely with SRH and HIV.

<p>* NHS England commissions - the contraceptive services commissioned by NHS England Area Teams (ATs) are an “additional service” defined in the standard GP contract (clause 9.3.1) as follows:</p>
<ol style="list-style-type: none"> 1. The giving of advice about the full range of contraceptive methods 2. Where appropriate, the medical examination of patients seeking such advice 3. The treatment of such patients for contraceptive purposes and the prescribing of contraceptive substances and appliances (excluding the fitting and implanting of intrauterine devices and implants) 4. The giving of advice about emergency contraception and where appropriate, the supplying or prescribing of emergency hormonal contraception or, where

the Contractor has a conscientious objection to emergency contraception, prompt referral to another provider of primary medical services who does not have such conscientious objections

5. The provision of advice and referral in cases of unplanned or unwanted pregnancy, including advice about the availability of free pregnancy testing in the practice area and, where appropriate, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objections
6. The provision of initial advice about sexual health promotion and sexually transmitted infections
7. The referral as necessary for specialist sexual health services, including tests for sexually transmitted infections

- 2.6. Local authorities and CCGs commission services on a population basis. NHS England has specialised commissioning hubs based in ATs which directly commission specialised services, including HIV, on a provider basis within a national specification.³ A similar single operating model applies to its other directly commissioned services such as sexual assault referral centres (SARCs) and the cervical screening programme.
- 2.7. In contrast, NHS England's ATs commission primary care on a population basis. GPs and primary care nurses have an important role in SRH providing contraceptive services, sexual health promotion and referral to specialist sexual health services. GPs may also be commissioned by local government to provide intrauterine devices and contraceptive implants through public health contracts.
- 2.8. The differing starting points of the commissioning models in local government, CCGs and NHS England could risk fragmentation of the care pathway for service users. This reinforces the need for a whole system perspective and a collaborative approach to designing and commissioning care pathways on a local basis.
- 2.9. Wherever commissioning responsibilities lie, SRH and HIV will always be complex and fascinating areas of public health and healthcare with clear links to other areas such as education, maternity services and the justice system. Whatever the national legislative framework, or local arrangements, there will always be a need to work collaboratively.

³https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284259/HIV_Sexual_and_Reproductive_Health_bulletin_issue_3_FINAL.pdf

Links to other sections:

- Section 6 provides more detail on areas where commissioning responsibilities interface
- Annexes 1, 2 and 3 provide details of policy, guidance and advice on SRH and HIV, relevant health and social care legislation and legal mechanisms to support commissioning
- Annex 4 gives further details on the structure of NHS England

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Section 3. Why take a whole system approach? Why it makes sense to the service user, the community and the commissioner

3.1 This section:

- describes effective commissioning in SRH and HIV
- outlines the benefits of investing in services and interventions for individuals, populations and public health
- identifies the drivers and rationale for whole system commissioning

3.2 Service users' needs for integrated pathways are at the heart of the case for collaborative whole-system commissioning. Following an HIV diagnosis, for example, it is essential to refer the patient to specialised services for a rapid assessment of viral load to decide whether antiretroviral (ARV) treatment should be initiated. Or following provision of emergency contraception, access to advice and provision of the full range of ongoing contraceptive methods, including LARC, is important. Poorly connected care means a risk of patients falling out of the system which can, for example, reduce their treatment adherence. Disjointed pathways also means opportunities may be missed to address the individual's wider needs, whether they relate to alcohol use, domestic violence or building self-esteem.

3.3 Three journeys illustrate how people might move between SRH and HIV services. These are not presented as "best practice" pathways but to demonstrate how the services used by a single individual are linked but commissioned by different organisations. The challenge for commissioners is to ensure people can access appropriate services and interventions along a seamless pathway.

A young woman's journey

3.4 *The first service user journey describes a young woman's use of open access SRH services. It illustrates the need to provide information, advice and care that support her positive sexual and reproductive health. To avoid unwanted pregnancy and treat an STI, she uses services commissioned by two local authorities and NHS England. Her story underlines the importance of open access, and confidential, young person-friendly services.*

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- 3.5 **Text for step one:** Young woman aged 17 attends health promotion session at college, given leaflet on contraceptive services. On a Saturday two weeks later, she gets emergency hormonal contraception (EHC), with information and options for ongoing methods from a pharmacist.
- 3.6 **Text for bubble one:** School health services and EHC service are commissioned by local government. EHC service is under Patient Group Directions (PGD).
- 3.7 **Text for step two:** Makes and attends appointment at her GP for contraceptive advice and provision, prescribed oral contraception.
- 3.8 **Text for bubble two:** Contraception is commissioned by NHS England as an additional service within the GP contract.
- 3.9 **Text for step three:** Three months later attends youth-friendly clinic for sexual health check, diet, exercise and smoking advice, receives results of positive chlamydia screen by phone and referred to an integrated SRH service for a full STI screen and partner notification (PN). This is located in nearest town and commissioned by a different authority.
- 3.10 **Text for step four:** attends early evening walk-in session at the integrated SRH clinic, treated for STI and PN discussed, (already had the tests and results from the young people's service).
- 3.11 **Text for bubble three:** Independent sector provider commissioned by local government to provide holistic preventive approach at youth-friendly clinic. Local government is responsible for providing open access services and is funded to support its residents through the public health grant. Re-charging of costs back to the area where the individual is resident is recommended for out-of-area use of services. These arrangements support open access integrated SRH services and patient choice.

A gay man's journey

- 3.12 ***The second service user journey*** describes the sexual health needs of a HIV-positive gay man. It underlines the importance of linkages and referral pathways between sexual health and HIV services. It also illustrates the wider needs of people living with HIV (PLWH) for treatment information and psychosocial support, which they may seek outside their local authority of

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residence to maintain confidentiality. Flexible funding mechanisms are required which match patterns of service usage.

- 3.13 **Text for step one:** A gay man in his early 20s attends an integrated SRH clinic, is diagnosed with gonorrhoea, given supply of condoms, referred to health adviser, has a negative HIV test.
- 3.14 **Text for bubble one:** Integrated SRH services commissioned by local government including HIV testing.
- 3.15 **Text for step two:** Returns to the integrated SRH clinic 6 months later with repeat gonorrhoea, accepts HIV test, tests positive, referred to HIV outpatient clinic.
- 3.16 **Text for bubble two:** HIV treatment and care services commissioned by NHS England. These are often provided at the same site as local government-commissioned sexual health services by the same team of professionals.
- 3.17 **Text for step three:** Seen at HIV outpatient clinic for assessment and evaluation, identified as needing referral to voluntary organisation for psychosocial support, receives patient treatment information.
- 3.18 **Text for step four:** ARV therapy initiated at second HIV outpatient appointment, sees health adviser and PN undertaken, sexual history taken and STI screen performed.
- 3.19 **Text for bubble three:** Psychosocial support services, PN and STI screens for PLWH are commissioned by local government.

A woman's pathway

- 3.20 *The third service user journey is that of an adult woman who has an unplanned pregnancy. The services she accesses are commissioned by a CCG and a local authority. She has wider health needs but these are poorly catered for as she is not able to access disparate services. The opportunity to meet her needs in an integrated way is therefore lost.*
- 3.21 **Text for step one:** A 37 year old woman attends integrated SRH service for a pregnancy test (positive result), has an STI screen and receives advice on choice of contraception. Following discussion, seeks referral to abortion service.

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- 3.22 **Text for bubble one:** Open access integrated SRH service is commissioned by local government.
- 3.23 **Text for step two:** Attends abortion service, discussion with clinician identifies problems with alcohol use, opts for termination of pregnancy and given date for attendance.
- 3.24 **Text for bubble two:** Abortion service is commissioned by CCG.
- 3.25 **Text for step three:** Attends for day case abortion, is given condoms, sees counsellor within the service who refers to women's alcohol advice service and encourages return to integrated SRH service for contraception.
- 3.26 **Text for step four:** Fails to attend appointment at alcohol advice service and does not return to integrated SRH service for contraception. No mechanism exists for follow-up between different services and opportunity to support this young woman is lost.
- 3.27 **Text for bubble three:** Local government and CCG to should ensure service and contracting arrangements support an effective integrated pathway for service users.

Effective commissioning in SRH and HIV

- 3.28 Effective commissioning understands and addresses the wider determinants of sexual health (such as age, gender, sexuality, and cultural, social, educational and economic factors). It assesses and meets the SRH and HIV needs of people at all life stages, improving health outcomes for individuals and populations through:
- User-focused services with integrated care pathways
 - preventative interventions targeting those most in need
- 3.29 There has never been a greater need for public services to work together at a local level, pooling expertise and resources in a collaborative, whole system approach. In doing so the inter-related SRH and HIV health needs of service users – across primary and secondary care, and between secondary care specialties – are recognised and put at the heart of the commissioning process. It is important to recognise collaborative commissioning arrangements will not be driven centrally, but must be established locally.
- 3.30 Dialogue within and across organisations is essential as initiatives and plans are developed – for example, CCG and local government work together to

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make every contact count and to integrate health and social care, and as NHS England’s five-year specialised services strategy is developed .

- 3.31 Collaboration can ensure service use patterns are reflected, innovation is fostered and best value is obtained from limited resources. For example, NHS England colleagues can seek to add value through collaborative commissioning of specialised services, primary care services and other directly commissioned SRH and HIV services. Similarly, within local authorities, collaboration between public health and other departments will further strengthen the impact of commissioning.
- 3.32 These arrangements might include creating a bigger commissioning footprint, by making formal agreements to commission across several local authorities or establishing local lead commissioning arrangements for specific integrated care pathways.
- 3.33 To achieve shared commissioning objectives in SRH and HIV, all parties – commissioners, clinicians in primary and secondary care, voluntary and community organisations, patient and public representatives – will need to be around the table.

Figure 2 – Public Health and NHS Outcomes Frameworks: progress and challenges
[DN: these boxes will appear throughout the document once designed]

Public Health Outcomes Framework Indicator	Progress	Challenges
Under 18 conception rate per 1,000 population	The under-18 conception rate for 2012 was the lowest since 1969 at 27.9 conceptions per thousand women aged 15-17 ⁴ .	England has one of the highest rates of teenage pregnancy in western Europe ⁵ .

⁴ Conceptions in England and Wales 2012, Office for National Statistics, 2014

⁵ National Institute for Health and Care Excellence. Contraceptive services with a focus on young people up to the age of 25. NICE public health guidance 51. 2014.
<http://publications.nice.org.uk/contraceptive-services-with-a-focus-on-young-people-up-to-the-age-of-25-ph51> Accessed on: 14/04/2014.

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Public Health & NHS Outcomes Framework indicators	Progress	Challenges
<p>People presenting with HIV at a later stage of infection (PHOF)</p> <p>Preventing people from dying prematurely (NHS Outcomes Framework)</p>	<p>People living with HIV can now expect a near-normal life expectancy and better clinical outcomes if diagnosed promptly and linked to HIV care.</p> <p>97% of people diagnosed in 2012 were linked to HIV care within three months.</p> <p>The proportion of people with HIV diagnosed late (CD4 count <350 cells/mm³) has declined over the past decade from 58% to 47%.</p>	<p>One in five people living with HIV in the UK remains undiagnosed. It is estimated that the majority of onward transmission is from those with undiagnosed HIV.</p> <p>51% of new HIV diagnoses in 2012 were among men who have sex with men (MSM), the highest annual number ever reported in the UK. Nearly one in 20 MSM is estimated to be living with HIV.</p> <p>The 47% of people with HIV who are still diagnosed late have a ten-fold increased risk of death in the first year of diagnosis compared to those diagnosed early.</p>

PHOF indicator	Progress	Challenges
<p>Chlamydia diagnoses (15-24 year olds)</p>	<p>Since 2000, substantial increases have been noted in attendance at sexual health clinics (from 6.7% to 21.4% in women and from 7.7% to 19.6% in men).⁶</p>	<p>The proportion of young men who had a chlamydia test in the past year is less than two-thirds the proportion of young women (37% vs. 57%)⁷.</p>

⁶ National Survey of Sexual Attitudes and Lifestyles (NATSAL), Lancet, Vol 382, November 30, 2013

Figure 3

BOX 1

3.34 *Did you know?*

- an estimated £762m was spent in 2010 on HIV treatment and care⁸
- implementing the NICE guidance on increasing uptake of HIV testing among MSM and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18m in treatment costs per year⁹

BOX 2

3.35 *Did you know?*

- long-action reversible contraception (LARC) methods are more clinically and cost effective than the combined oral contraceptive pill even at 1 year of use¹⁰
- IUDs, the IUS and the implant are more cost effective than injectable contraceptives¹¹
- the annual net saving from increased use of LARC would be £102m¹²

BOX 3

3.36 For more information on cost effectiveness of:

- **LARC** – see the national cost-impact report: *Implementing the NICE clinical guideline on long-acting reversible contraception (NICE, 2005)*¹³
- **HIV screening and testing** – see *Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary (PHE, 2014)*¹⁴

⁷ National Survey of Sexual Attitudes and Lifestyles (NATSAL), Lancet, Vol 382, November 30, 2013

⁸ Health Protection Agency. HIV in the United Kingdom: 2011 Report. 2011; http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131685847 Date accessed: 4-4-2014

⁹ National Institute for Clinical Excellence. Increasing the uptake of HIV testing among black Africans in England and increasing the uptake of HIV testing among men who have sex with men: Costing report - Implementing NICE guidance. 2011; <http://www.nice.org.uk/nicemedia/live/13413/53684/53684.pdf>

¹⁰ National cost-impact report: Implementing the NICE clinical guideline on long-acting reversible contraception 2005; <http://www.nice.org.uk/nicemedia/live/10974/29916/29916.pdf>

¹¹ National cost-impact report: Implementing the NICE clinical guideline on long-acting reversible contraception 2005; <http://www.nice.org.uk/nicemedia/live/10974/29916/29916.pdf>

¹² National cost-impact report: Implementing the NICE clinical guideline on long-acting reversible contraception 2005; <http://www.nice.org.uk/nicemedia/live/10974/29916/29916.pdf>

¹³ <http://www.nice.org.uk/nicemedia/live/10974/29916/29916.pdf>

¹⁴ http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317141126407

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- **opportunistic chlamydia screening** – see *Opportunistic Chlamydia Screening of Young Adults in England: An Evidence Summary (PHE, 2014)*¹⁵

See also **Leaders' briefings** on HIV screening and testing¹⁶ and opportunistic chlamydia screening.¹⁷

Benefits of investing in a collaborative whole system approach

3.37 As illustrated above, the most important driver for whole system commissioning is the need to ensure meaningful, integrated pathways for service users. In addition to this there are a number of other important drivers for whole system commissioning:

- ✓ policy and indicators to support commissioning
- ✓ the benefits arising from investment in effective services and interventions
- ✓ the requirement to meet population needs at all life stages
- ✓ the mandate to commission open access services
- ✓ economic and technological change

3.38 Each of these is discussed below and the rationale they provide for whole system commissioning explored.

Policy and indicators to support commissioning

3.39 National policy documents provide a starting point for the development of local plans and priorities and offer key indicators by which to measure progress in achieving outcomes. Key policy, guidance indicators, standards and service specifications are outlined in Annex 1. Annex 3 outlines the essentials of the policy background for SRH and HIV.

3.40 *A framework for sexual health improvement in England*, the key policy document for SRH and HIV, states: "It will be vital for commissioners to work together to ensure that the care and treatment people receive is of a high quality and not fragmented."¹⁸

¹⁵http://www.chlamydia-screening.nhs.uk/ps/resources/evidence/Opportunistic%20Chlamydia%20Screening_Evidence%20Summary_April%202014.pdf

¹⁶ http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317141126520

¹⁷

http://www.chlamydia-screening.nhs.uk/ps/resources/evidence/Opportunistic%20Chlamydia%20Screening_Leaders'%20Briefing_%20April%202014.pdf

¹⁸ A Framework for Sexual Health Improvement in England, Department of Health, 2013, page 41

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Investing in effective services and interventions

3.41 Investing in effective SRH and HIV services and interventions reduces sexual ill health and brings wider benefits to individuals and society. The examples in figure 4 illustrate the interdependency of the benefits for different commissioning organisations. Investment in one area may benefit more than one commissioning organisation across the system.

Figure 4. Benefits of investment in effective services and interventions for individuals, the public and commissioners

Key objectives in A Framework for Sexual Health Improvement in England	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes)
<p>Objective: Continue to reduce the rate of under 16 and under 18 conceptions.</p> <p>Commissioning intention: Ensuring choice and timely access to young people friendly reproductive health services and all methods of contraception.</p>	<p>Control over fertility through Increased use of contraception</p> <p>Greater ability to pursue educational and employment opportunities</p> <p>Improved self-esteem.</p> <p>Improved economic status/reduction in family and child poverty</p>	<p>Fewer unwanted pregnancies</p> <p>Improved health outcomes for mothers and babies</p> <p>Better educational attainment</p> <p>Better employment and economic prospects</p>	<p>Improved infant mortality rates (CCGs)</p> <p>Reduced A&E admissions/childhood accidents (CCGs)</p> <p>Decrease in abortions (CCGs).</p> <p>Reduced use of mental health services (CCGs).</p> <p>Reduced use of social services (LAs)</p> <p>Fewer young people not in education, employment or training (LAs)</p> <p>Reduction in family and child poverty (LAs)</p>
<p>Objective: Reduce rates of STIs among people of all ages.</p> <p>Commissioning</p>	<p>Treatment of STIs</p> <p>Reduced risk of other health consequences (e.g. pelvic inflammatory</p>	<p>Reduction in prevalence and transmission of infection</p> <p>Opportunities to</p>	<p>Reduced use of gynaecology services (to manage other health consequences) (CCGs)</p>

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<p>intention: Encouraging uptake of chlamydia screening and testing for under 25 years olds.</p>	<p>disease, tubal-factor infertility, ectopic pregnancy)</p>	<p>test for other STIs/HIV in those diagnosed with chlamydia</p> <p>Reaching young people with broader SRH messages</p> <p>Increased uptake of condom use</p>	<p>Increased uptake of SRH services by young people (LAs)</p> <p>Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence (LAs)</p>
<p>Objective: Reduce onward transmission of HIV and avoidable deaths from it.</p> <p>Commissioning intention: Ensuring access to HIV testing, early diagnosis and treatment initiation</p>	<p>Access to treatment</p> <p>Better treatment outcomes/prognosis</p> <p>Improved ability to protect partner from HIV</p>	<p>Fewer people acquiring HIV</p> <p>Greater contribution of people living with HIV to workforce and society</p> <p>Less illness and fewer avoidable deaths</p>	<p>Lower health and social care costs for HIV (NHS England, CCGs and LAs)</p> <p>Lower healthcare costs for associated conditions and emergency admissions (CCGs)</p> <p>Enhanced public health/prevention (LAs)</p>
<p>Objective: Reduce unintended pregnancies among all women of fertile age.</p> <p>Commissioning intention: Ensuring access to high quality reproductive health services for all women of fertile age.</p>	<p>Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods</p> <p>Optimisation of health for women prior to becoming pregnant</p> <p>Fewer abortions and repeat abortions for individual women</p> <p>Improved quality of family life</p>	<p>Fewer unwanted pregnancies</p> <p>Improved pregnancy outcomes</p> <p>Improved maternal health and reduced maternal mortality</p>	<p>Investment in contraception is cost effective in reducing pregnancies and abortions (CCGs)</p> <p>Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes (CCGs)</p> <p>Reduced social care costs for infant and childcare (LAs)</p>

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Commissioning to meet population need at all life stages

- 3.42 People's sexual and reproductive health needs vary at different stages in their lives. SRH and HIV services are used by people of all ages. Understanding the demography of actual and potential service users and specific populations should drive whole system commissioning.
- 3.43 Sexual behaviour is affected by wider social factors and this, in turn, has an impact on the acceptability of services and how they are used. Examples of the impact of the wider determinants of health include:
- low educational attainment and teenage pregnancy
 - recreational drug use and STI/HIV transmission risk behaviour [DN: reference MSM framework once published]
 - non-volitional sex at a young age and adverse health outcomes in both men and women
- 3.44 These wider issues need to be addressed collaboratively by all commissioners across SRH and HIV. Directors of public health, working with PHE colleagues, can advise on the implications of demography, health-seeking behaviour and disease burden for commissioning integrated care pathways and effective interventions.

Delivering the mandate to commission open access services

- 3.45 Local authorities are mandated to commission "open access" SRH services¹⁹. This means people can self-refer to the service of their choice regardless of location. Open access is offered because these services are in the frontline of managing communicable disease and enabling positive reproductive health, making it a priority to test and treat as many people as possible for STIs and to ensure women have access to contraception when they need it (see case study in Annex 6 on management of communicable disease outbreaks). Some people choose to use services outside their borough for reasons of convenience or confidentiality.
- 3.46 Commissioning and funding mechanisms, including cross charging arrangements, need to take account of how people actually use services and how best to meet their health needs. This is reflected in established collaborative commissioning mechanisms such as the Greater Manchester Sexual Health Network covering 10 local authorities, 12 CCGs and eight acute trusts (see case study 2).

¹⁹ The Local Authorities (Public Health Functions and Access to Premises by Local Healthwatch Representatives) Regulations 2013.

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Economic and technological change

- 3.47 SRH and HIV services are at the cutting edge of new technology in healthcare. Given the age profile of sexual health service users, there is great potential to maximise the use of advanced health technologies and social media in service development to deliver outcomes at a lower cost.
- 3.48 The current resource climate for public services makes cost efficiency a requirement and puts cost effectiveness under continual scrutiny.
- 3.49 Change will be driven by two pressures: evolving needs on one hand and reductions in funding on the other (sometimes characterised as supply and demand pressures). In this context, the push for improvement will drive fundamental changes in the design, commissioning and delivery of services.
- 3.50 The transaction costs of multiple commissioning relationships with individual providers are potentially high. Collaborative commissioning, especially, across a larger geographic footprint, makes sense.

Section 4. What are the levers and mechanisms to support whole system commissioning?

4.1 This section:

- identifies the leadership role of directors of public health (DPH) in helping to implement a whole system approach
- looks at the importance of values, principles and pathways in collaborative commissioning
- describes the roles, structures and processes which enable a whole system approach

4.2 To develop a whole system commissioning approach, the following actions are strongly recommended:

- **establish responsibility and leadership.** DPH agree with senior CCG and NHS England colleagues a lead who will oversee and co-ordinate across the whole system of SRH and HIV services to secure effective commissioning
- **map the system.** Each local area maps and understands services, pathways and linkages across the whole system and agrees consistent pathways against which to commission
- **agree how to communicate and work together.** Each local area brings together SRH and HIV commissioners on a regular basis. The level and formality of collaborative arrangements will be for local decision. They might, for example, include an interagency partnership board, chaired by the DPH, reporting to the health and wellbeing board and/or a local commissioners' forum or funding arrangements such as pooled budgets and/or Section 75 agreements

4.3 Many areas already have such arrangements and examples are described in the case studies. Annex 2 describes an example of the use of Section 75 of the NHS Act 2006 to commission integrated services for children and young people. Commissioners may also draw upon experience in other healthcare areas. The Better Care Fund provides an opportunity and impetus for system leadership.

4.4 Set out below are a range of mechanisms available to commissioners to support whole system commissioning and the individual levers that can be used.

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Mechanism: local system leadership

4.5 The new world requires a collaborative approach. The Health and Social Care Act 2012 promotes the principle of integrated working between NHS bodies and local authorities. Local authorities, CCGs and the wider NHS have a duty to co-operate (see Annex 2). Local system leadership takes shared purpose, relationship and trust at all levels. Individuals need to understand the economic climate, look beyond their organisation and create the space for challenging discussions. Leaders need to foster an environment in which people are freed to think and do things differently going beyond delivering more or less of the same.

Lever: health and wellbeing boards

4.6 HWBs are the lynchpins of systems leadership. They have statutory duties and responsibilities to promote integrated working between commissioners of health related services and to reduce inequalities. HWBs also assess current and future health and care needs through Joint Strategic Needs Assessments (JSNAs) and set objectives to meet them in Joint Health & Wellbeing Strategies (JHWSs). HWBs have an important role in determining joint priorities between local government and the NHS, driving and monitoring progress. They set strategic objectives for SRH and HIV and hold commissioners accountable for delivering them.

Lever: role of director of public health

4.7 A key role of DPH is leadership to hold the system together and enable it to deliver on shared strategic objectives set by HWBs. This is highlighted in DH guidance²⁰ on their roles and responsibilities that states DPH: *“contribute to and influence the work of NHS commissioners, helping to lead a whole system approach across the public sector.”*

4.8 DPH and their teams also deliver the local authority’s mandated function to advise CCGs on population health which will inform and strengthen their commissioning decisions.

4.9 Local commissioning partners are best placed to determine how to deliver a whole system approach for SRH and HIV. DPH are well positioned to work with senior NHS counterparts to put appropriate collaborative mechanisms in place. The focus needs to be on fostering new ways of working and innovative

²⁰ Directors of Public Health in Local Government Roles, Responsibilities and Context, Department of Health, 2013

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approaches to meet population need and deliver integrated care pathways across the system.

Lever: PHE centres and intelligence hubs

4.10 As well as advising NHS England, 15 PHE Centres and eight intelligence hubs work with all SRH and HIV commissioners through the centres' sexual health staff. They can offer expertise and share experience from a regional and national perspective. As such they are well placed to contribute to collaborative whole system commissioning. They can share public health intelligence and evidence of proven success in addressing challenges from other settings and areas. They are also able to facilitate community engagement and the development of an integrated public health system.

Figure 5. Governance and accountability
[Diagram to be inserted in final draft]

Mechanism: values and principles

4.11 The most effective whole system approaches are based on shared values and principles. Agreeing local values and principles is a powerful way to develop relationships between commissioners. Agreed values and principles give a framework to help people from different organisations to work together, understand each commissioner's priorities and pressures, and help build clear and collaborative communication.

4.12 *A framework for sexual health improvement in England* outlines principles of best practice in sexual health commissioning. These can be adopted and adapted. Values might include equity, empowerment and accessibility. It is up to each commissioning group to identify what this means in their area. In Kingston upon Thames joint commissioning is based on a single set of principles between the local authority and CCG (see case study 1).

Mechanism: pathways and interdependencies

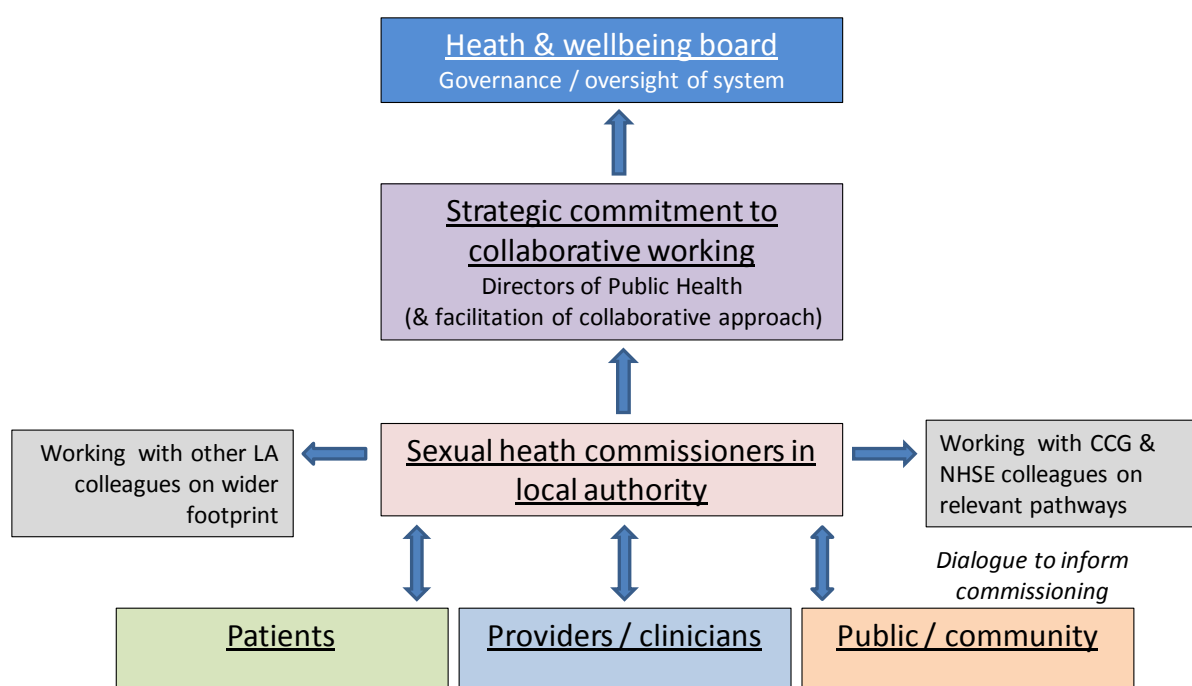
4.13 As illustrated in Section 3, all commissioners need to understand how service users access and move between different SRH and HIV services including primary care. To achieve this, commissioners need to assess and understand need and document the linkages and referral patterns between services. All stages of commissioning including redesigning services, drawing up specifications, setting standards and tendering, will be informed by these interdependencies.

4.14 Commissioners need to analyse how decisions taken by one organisation may affect other services in the system. In a whole system approach commissioners

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jointly assess and test the impact of decisions across the system at key points in the commissioning cycle; for example, prior to a tendering exercise. Commissioning decisions related to GUM services may impact on HIV treatment and care services or go beyond SRH and HIV services to impact CCG-commissioned pathology services. Commissioners should ensure capacity; supply and demand can be managed across the full range of services, and open access maintained.

Figure 6. Whole system commissioning in practice – a local government perspective



Mechanism: engagement and participation

4.15 Effective commissioners engage and consult widely with clinicians, the voluntary sector, service users and the public. Figure 7 highlights roles, structures and processes, already in place, which relate to all three commissioning organisations and facilitate this engagement in a whole system approach. Overview and scrutiny committees, Healthwatch, clinical senates and networks bring critical expertise to the table to engage in resource debates, service design, standard setting and other commissioning processes. Their role is described below and their contribution described in several of the case studies.

Figure 7. Engagement and participation in whole system commissioning [Diagram to be inserted in final draft]

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Lever: overview and scrutiny committees

4.16 Local authority overview and scrutiny committees were established under the Local Government Act 2000. Their remit is to scrutinise local health services, making recommendations to the council and NHS bodies for service improvement. Hackney Scrutiny Commission (see case study 3) demonstrates how the scrutiny process takes an integrated perspective across health, social care and public health.

Lever: healthwatch

4.17 Healthwatch England and local Healthwatch organisations are a statutory mechanism for public involvement. Healthwatch England provides a national voice while local organisations aim to give citizens greater influence over their health and social care services. A representative of the local Healthwatch organisation sits on the health and wellbeing board as a statutory member. Healthwatch organisations' focus is an integrated one across health and social care. They provide an important channel for community engagement in collaborative commissioning.

Lever: clinical senates

4.18 Clinical senates were set up to help CCGs, local authority health and wellbeing boards and NHS England to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level. They are non-statutory independent bodies established as part of the Health and Social Care Act 2012. They bring together commissioners, clinicians, patients, public health and social care experts to provide a strategic view across local and wider geographical areas. The South West Clinical Senate demonstrates how they act as a critical friend (see case study 4). Specialised services commissioning has been informed through South West Clinical Senate Council's deliberations on HIV which addressed key regional issues. Clinical senates can provide valuable advice to commissioning organisations.

Lever: networks

4.19 SRH and HIV services are organised into networks in several areas. Networks bring together providers for service delivery and act as a focus for clinical advice to commissioners, for example on setting and maintaining standards or developing shared pathways and protocols. Networks can also be the focus of commissioning across several local authorities. The Greater Manchester Sexual Health Network is a well-established network of commissioners and providers across ten local authorities, 12 clinical commissioning groups and eight acute trusts. (See case study 2).

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4.20 Support to a whole system commissioning approach is also provided through the English Sexual Health and HIV Commissioners Group (see case study 15). This offers a virtual forum for sharing experiences between SRH and HIV commissioners. The group's work is described in detail in section 5.

4.21 In summary, a whole system commissioning approach is based on:

- an agreed framework for local systems leadership
- shared values and principles for partnership work
- shared understanding between commissioners of the linkages across the system and the public health value of integrated care pathways
- care pathways across SRH and HIV services agreed by commissioners from all three commissioning organisations
- commissioning decisions taken against agreed care pathways and shared outcomes which are consistent across the whole system
- regular strategic review of key indicators, outcomes data and success criteria (such as by health and wellbeing boards)

Section 5. How to work collaboratively to deliver improved outcomes

5.1 This section:

- outlines how to commission collaboratively for better outcomes
- proposes local actions to address whole system commissioning issues
- includes emerging commissioning practice case studies

How to commission collaboratively

5.1.2 Whole system commissioning takes local system leadership and collaborative approaches at all levels. It also requires clarity on how funding follows the service user, how tendering and contracting will operate, the shared development of service specifications and agreement on standards, outcomes, data sharing and monitoring. Commissioners will need to engage with providers, clinicians, local political leaders, service users and voluntary and community organisations.

5.1.3 There is no one right way. Commissioners are best placed to tailor actions to meet commissioning challenges to their local context. The case studies share practical experience from commissioners in urban and non-urban settings as they develop collaborative commissioning models and practices. The local actions proposed in this section focus on:

- building collaborative commissioning arrangements
- securing stakeholder engagement
- securing best value
- developing collaborative funding arrangements
- managing procurement
- implementing change
- driving quality improvement and service development

5.1.4 Section 6 will focus on local actions to support commissioning of integrated pathways.

Figure 8. Building blocks of collaborative commissioning



5.2 Building collaborative commissioning

✓ *Establish formal working relationships*

Arrangements between local authorities

5.2.1 Consider agreeing a formal overarching commissioning framework covering more than one local authority as a means to secure efficiencies, promote equity and manage the risk arising from open access services. In Berkshire (see case study 5) six unitary authorities have established a shared team to manage the new public health responsibilities including commissioning SRH services. In North West London, nine local authorities are collaboratively commissioning GUM services (see case study 8).

Arrangements across a geographical area

5.2.2 Assess the case for a unified framework for commissioning SRH and HIV services, whether across a smaller or larger geographical area. This should

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include agreement on how the respective commissioning responsibilities of the local authority/authorities), CCG(s) and NHS England could be aligned within a wider framework. Make sure to consider the implications of such a framework for both contraception and STI management, and how it can support the commissioning of integrated SRH services. Establishing collaborative arrangements for one element of service, but not others, may make it unduly complex for providers that are delivering innovative, integrated services. Review how HIV specialised services might also be included. The Greater Manchester Sexual Health Network provides an umbrella for a number of multilateral collaborative commissioning arrangements (see case study 2). If all three commissioning bodies are not unified within a single collaborative framework, identify, mitigate and jointly manage the risks.

Linked business processes

5.2.3 Build close collaboration between commissioners and colleagues from finance, legal and procurement departments of different organisations. Do not underestimate the time required to develop collaborative commissioning arrangements and associated financial, tendering and contracting processes.

5.2.4 Make sure arrangements are documented to:

- satisfy governance and compliance requirements
- manage any pooled finance or shared human resources
- detail the specific responsibilities of host or lead commissioners
- identify authority for contract sign-off
- outline arrangements for performance management.

(See case studies 5, 8 and 10).

✓ *Manage risks arising from interdependencies*

Linked needs and interdependent services

5.2.5 People's SRH and HIV-related needs are linked as are the services required to meet them (see Section 3), so the planning of each area of care will have implications for the planning of the others. Make sure all commissioners have a clear understanding of the local interdependencies between SRH and HIV services and other aspects of care. This should be based on a joint assessment of service user needs, and of the care pathways and provider relationships required to meet those needs.

Interdependence between HIV and GUM

5.2.6 Be alert to the critical interdependencies between GUM and HIV outpatient clinics which are often provided by the same service. NHS England specialised commissioners in ATs, and local authority sexual health commissioners, should assess these links, notably clinical expertise, training and education and

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infrastructure. As commissioners in ATs implement NHS England's strategy for consolidation of specialised services, the risk of destabilisation should be jointly managed with sexual health commissioners. Where sexual health commissioners have plans to market test, these should be shared at an early stage with NHS England colleagues. NHS England has asked ATs to work collaboratively with colleagues in local authorities and PHE centres supported by the accountable commissioner for the HIV Clinical Reference Group (CRG). (See case study 9).

5.3 Securing stakeholder engagement

✓ *Engage effectively with local political leaders*

Roles of political leaders

5.3.1 Recognise the valuable contribution local political leaders bring to collaborative commissioning in SRH and HIV, including:

- Governance of public health expenditure
- Scrutiny of local health and social care services
- Promotion of integrated working between commissioners of health-related services.

5.3.2 Elected members can act as strong advocates for SRH and HIV. Ensuring they understand local need and the contribution services can make to tackling those needs is essential to this process.

5.3.3 In Oxfordshire, commitment to procuring an integrated sexual health service was approved by the Cabinet member for Public Health (see case study 11). In North West London, governance processes were required to establish a collaborative commissioning arrangement between nine local authorities (see case study 8).

High-level enabling of collaboration

5.3.4 Take opportunities to engage local political leaders in developing collaborative arrangements within local government and with the NHS. Local government commissioners, where appropriate with CCG and AT colleagues, can provide regular briefings and reports for local political leaders on SRH and HIV issues through health and wellbeing boards, council committees, scrutiny exercises and community engagement processes. These should explore the opportunities for collaboration across local government departments to promote wellbeing, prevent ill health and address wider issues of vulnerability, for example, in young people. Northumberland's public health department is maximising the

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opportunities to work across local government and with health services to meet the needs of vulnerable adolescents (see case study 12).

✓ *Involve service users, the public, and community organisations*

Diverse community engagement

5.3.5 Work with Healthwatch, SRH and HIV advocacy and service user organisations, and local government community engagement forums, to involve services users and the public in the commissioning process. In Darlington, young people requested the teenage pregnancy and sexual health steering group to organise separate interactive young people's stakeholder events (see case study 13). Mixed methods are needed to capture the views of actual and potential service users as well as representative voices.

✓ *Securing best value*

Payment mechanisms

5.3.6 Establish local criteria to assess which payment mechanisms provide best value. The benefits of tariffs are articulated in the Sexual Health Commissioning *Frequently Asked Questions* document²¹. Commissioners may choose to use the integrated SRH tariff or develop local tariffs for SRH services. Commissioners in Leicester, Leicestershire and Rutland aimed to introduce an integrated sexual health tariff to generate savings (see case study 10). Both tariff and block arrangements can be used effectively to incentivise providers and achieve commissioning objectives, for example through the application of marginal rates or additional payments if activity exceeds a certain percentage of the agreed level. Both block and tariff arrangements can deliver value for money and high quality services depending on how they are structured and managed.

Cross-charging

5.3.7 The Advisory Committee on Resource Allocation (ACRA) has expressed the view that cross-charging is the best way to handle service use by non-residents applicable to sexual health. Existing documents²² provide further information on cross charging, including the suggestion that if the two-way patient flow between two areas is of a similar level, and therefore 'cancel each other out', commissioners may wish to reach reciprocal arrangements whereby activity is not invoiced as the administrative burden outweighs the marginal differences in

²¹ Sexual Health Commissioning - Frequently Asked Questions – Published February 2013; LGA; ADPH; PHE, February 2013

²² Department of Health. Sexual Health Services: Key Principles for Cross Charging, 2013; Public Health England, HIV, sexual and reproductive health: current issues bulletin: issues 1, November 2013

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patient flow between the two areas. Some local authorities are considering adopting this approach across a number of authorities.

Savings through collaboration

5.3.8 Identify how collaborative commissioning can enable savings to be made in specific areas of care. Savings generated in one area can allow reinvestment in another area.

5.3.9 Identify where economies of scale can be achieved through collaborative commissioning. Savings generated through jointly procuring services, supplies or drugs (such as condoms, ARVs) or reduced transaction costs of commissioner/provider contractual relations, can be reinvested in services/interventions.

Strategy development

5.3.10 Base your funding strategy on an assessment of which mechanisms best match local commissioning objectives. The strategy should address value for money assessments, analysis of the benefits of investment to save approaches, payment mechanisms, tendering, pooling of resources, quality improvement and productivity gains.

Data monitoring

5.3.11 Ensure effective financial and activity data monitoring is in place. Activity and financial data, which can offer a better understanding of case mix, new to follow-up ratios and numbers of complex cases, is needed to inform financial planning. It can also help in assessing the impact of payment mechanisms on value for money and how efficiencies may be made through investment, service development or redesign.

Challenges

5.3.12 Understand the factors influencing future funding for SRH and HIV, for example the possible lifting of the ring fence on the public health grant, the tension between a residential funding base and open access service regulations, and the continued annual growth in new HIV diagnoses. Plan collaboratively to meet these challenges.

Solutions

5.3.13 Plan to meet future resource challenges through, for example:

- service redesign (see case study 6)
 - targeted training such as LARC or dual training in sexual and reproductive health
- Investing in prevention

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- demand management initiatives, in particular, looking at case mix across different services and identifying how and where differing levels of complexity of need are best met; including a targeted approach to using primary care for appropriate services
- using benchmarking to review service costs with providers

5.4 Developing collaborative funding arrangements

✓ *Explore options*

Collaborative funding approaches

5.4.1 While developing collaborative commissioning arrangements, explore the implications for finance and procurement. Approaches to funding mechanisms differ and collaborative arrangements are not necessarily based on pooled funding (see case studies 1 and 6). Assessing which options are appropriate in a given context requires senior engagement and a high level of investment of officers' time.

5.4.2 Different approaches to contracting on behalf of two or more commissioning bodies are summarised in Figure 9.

Figure 9. Options for contracting on behalf of multiple commissioners

Services commissioned	Commissioners contracting	Contractual arrangements
Operational integration across services (information sharing and referral pathways between staff)	2 or more	Separate contracts and services
Seamless pathways between services	2 or more	Separate services and contracts (describing overlaps or shared elements in each contract)
Services designed in collaboration to develop single specification	2 or more	One specification/two or more contracts
Shared services	1	Two specifications/one contract/
Fully integrated services, with or without commissioner pooled budgets (via section 75/ LA agreement)	1	One or two specification/one contract
A network of services or a number of providers in a defined area covering several CCGs/LAs/NHS England area	1 or more	One specification/2 or more contracts

teams		
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✓ *Agree shared funding arrangements*

Written agreements

5.4.3 Underpin shared funding arrangements with written agreements between the lead commissioning agencies and their partners. Such agreements should cover principles of risk sharing, accountability, budget planning and management, reporting and risk management. Pooling resources gives greater flexibility to manage risk in an open access service. Assessing the accuracy of costing and coding across the services commissioned and improving it where necessary is an important foundation of shared funding.

Section 75

5.4.4 Consider developing partnership arrangements, including pooled funding, under Section 75. NHS England is permitted to participate in collaborative commissioning under a section 75 agreement where all parties agree to do this and where this is authorised from NHS England's perspective by the Regional Office²³. Local authorities and CCGs already have experience of this approach to address other health needs (see case study and further information in Annex 2). The collaborating bodies need to agree on lead commissioning arrangements as well as the contract to use, based on legal advice to all parties.

Areas of commissioning overlap

5.4.5 Where there are overlaps in commissioning responsibilities (as identified in section 6) start with the service user's pathway and design services that make sense from the user's perspective. Then ensure that contractual arrangements support this service design in the most effective way. There is a strong case for establishing a lead commissioner. The budget could be pooled across a local authority and CCG or recharged by the lead commissioner. The Wigan case study offers valuable experience of lead commissioning arrangements for abortion services (see case study 7).

5.5 Managing procurement

✓ *Secure clinical engagement without compromising transparent procurement*

²³ "HIV, sexual and reproductive health: current issues bulletin No 3, PHE DH, LGA, NHS England and ADPH, February 2014

Boundaries for engagement

5.5.1 Identify clear boundaries for clinical engagement in developing service models, service specifications and standards. The input of clinical expertise and understanding of 'on the ground' service delivery is a vital part of the commissioning process. Yet local clinicians may have a vested interest in the outcome of commissioning decisions, so it is important to define clearly how their engagement will be managed. In specialised services this is achieved at a national level through the HIV clinical reference group (CRG) which provides a useful model including the contribution of clinicians, patients' organisations and professional associations. The CRG developed the draft national specifications for adult and children's specialist HIV services. Commissioners in Berkshire decided to use a local CRG to develop service standards, with the final version being externally reviewed. The Faculty of Sexual and Reproductive Healthcare (FSRH) and the British Association for Sexual Health and HIV (BASHH) have compiled a list of their members who would be willing to offer local authorities expert clinical input into sexual health contracting processes. Commissioners in Leicester, Leicestershire and Rutland found engaging external facilitators gave credibility to their service redesign process when developing an integrated care model (see case studies 5 and 10).

Further advice on tendering and procurement

5.5.2 Further advice on this and other tendering and procurement issues can be found in the HIV, Sexual and Reproductive Health Current Issues Bulletin 4²⁴.

✓ *Manage the market*

Needs-based procurement

5.5.3 Base decisions about procurement on a thorough sexual health needs assessment which builds on the JSNA.

Collaboration to manage risk

5.5.4 Develop and review procurement plans with colleagues at the earliest possible stage. Parallel procurement processes without effective risk assessment and mitigation between commissioners could have unintended consequences, such as rendering unviable a 'rump' HIV service previously run within GUM when tendering for a new integrated SRH service to be provided in the community.

²⁴ HIV, sexual and reproductive health: current issues bulletin, No 4, PHE, DH, LGA, NHS England, ADPH, May 2014

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Shared learning

5.5.5 Learn from, and share, experience of managing markets locally and through the Association of Directors of Public Health, PHE or English Sexual Health and HIV Commissioners' Group. Local government's experience of obtaining best value and market management can inform the commissioning of integrated SRH services.

Market stimulation

5.5.6 Consider holding stakeholder events for potential providers from all sectors to test market capacity and explore differing approaches to delivering a new service model. If a prime contractor model is proposed (where a lead contractor holds the contract for services delivered by a number of providers), stimulation of tendering partnerships may be needed. This could apply especially if the service specification requires providers to meet the needs of vulnerable or hard to reach groups and/or if voluntary sector providers are needed to provide an element of the service.

5.6 Implementing change

✓ *Create a sustainable workforce*

Education and training

5.6.1 Define in service specifications what is required of providers to enable education and training for the whole workforce. The assessment panel for tenders needs to include relevant expertise in training and education. In Leicestershire this was provided by the local education and training board (LETB) (see case study 10).

Safeguarding undergraduate and postgraduate education

5.6.2 Make yourself aware of education and training issues for specialist and non-specialist training in which both SRH and HIV services play a significant role. Commissioners should ensure they do not undermine the capacity to develop future generations of doctors and nurses. Training provision is the responsibility of the LETB. Providers employ the trainees and receive funding from LETBs based on a Learning Development Agreement. Be aware that training in genitourinary medicine requires experience in both GUM or integrated SRH and specialised HIV services. In developing service specifications, engage at an early stage with local academic and training institutions, LETBs and any local training advisers in SRH or HIV, such as FSRH advisers, for expert advice.

Training for qualified professionals

5.6.3 Ensure training is supported for qualified professionals to deliver services under all contracts eg LARC fitting for contraceptive and non-contraceptive purposes

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in all relevant settings, or provision of emergency hormonal contraception in pharmacies. Primary care staff maintaining their competence and accreditation facilitates diversity and choice for women in contraceptive methods. Secondary care staff maintaining their competence and accreditation supports the provision of integrated care pathways for service users. Seek advice from the LETB about how they can support such training provision.

✓ *Manage de-commissioning and mobilisation*

Opportunities to review service provision

5.6.4 New commissioning responsibilities and new collaborative arrangements provide commissioners with the opportunity to review current service provision. In some circumstances this will identify services that are no longer meeting local need. De-commissioning these services will release valuable resources which can be reinvested in services that better meet the needs of the local population.

Change management

5.6.5 Recognise that each set of circumstances in which services are de-commissioned and new services mobilised is unique, but the principles of change management can be applied to the process. The impact may ripple across the whole system and should therefore be jointly assessed and managed. Commissioners who have experience of these processes advise:

- Building in sufficient start-up time for a new provider to mobilise
- Identifying the workforce and human resource challenges which may occur for the existing and future providers
- Testing robustly at a senior level all assumptions regarding the outgoing provider's willingness or ability to co-operate with the new provider.

Infrastructure and key staff

5.6.6 Clarify whether new providers will have access to infrastructure and key staff following de-commissioning. In particular:

- Understand the situation regarding future use of premises occupied by the incumbent provider
- Understand the role of individual staff employed by the incumbent provider whose time is split between services commissioned by different bodies, such as GUM physicians providing both integrated SRH and specialised HIV care. Clarify what their future availability and role would be if one of these aspects of care was moved to a new provider.

5.7 Driving quality improvement and service development

✓ *Support evidence-based practice and service development*

Research and development

5.7.1 Recognise the importance of research and development in driving improvements in HIV clinical care and in the modernisation of SRH services. NHS England has stated that “research and evaluation across the whole patient pathway including with partners in local government and PHE will contribute to improving outcomes and spreading innovation and economic growth”. Commissioners should therefore welcome provider participation in clinical studies and in operational research and evaluation through, for example, National Institute of Health Research (NIHR) and Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) funded programmes. Ensure that the commissioning of services does not impede participation in research and development.

Evidence-based commissioning

5.7.2 Base local commissioning on the best available evidence including clinical, scientific and operational research whether nationally or locally generated. Public health experts, through local government departments and PHE, are well placed to advise as are clinical and social science departments in academic health science centres and local universities. Share the findings of local research between commissioners and providers through established networks and forums. Where utilising research evidence has financial implications, it should be a managed process between commissioners and providers

✓ *Agree a joint approach to quality improvement*

Shared specifications and standards

5.7.3 Driving improvement in quality and outcomes across a local area is premised on a shared approach to specifications, standards, outcomes, data sharing and monitoring. Whatever funding mechanism is used, start with a shared specification and agreement between commissioners on standards and outcomes to be achieved. These should draw not only on national standards and outcomes frameworks but also on local and national research as a foundation for evidence-based practice and service development.

Measuring outcomes

5.7.4 Agree ways of measuring quality and outcomes across the local system. Jointly monitor services against baseline indicators from the strategic needs assessment and these identified quality measures. Where research and

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evaluation activities are linked to the identified quality and outcome measures, findings should be widely disseminated.

Data sharing

5.7.5 Agree a data-sharing protocol to support system-wide activity and performance monitoring (see case study 6). This can help ensure consistency in standards and quality of service delivery. Requiring providers to collect the same data for all commissioners minimises duplication and focuses effort on key indicators and quality measures (see case study 8). It also ensures that any benchmarking of services is based on data collected to a common definition.

Performance monitoring

5.7.6 Agree a streamlined process for performance monitoring visits, either undertaken collaboratively or formally delegated to a host or lead commissioner with reports back to other agencies. This avoids duplication, saving staff resource for both commissioners and providers; and facilitates in-depth relationships between providers or provider networks and their commissioner(s). Greater Manchester Sexual Health Network has collaboratively developed an abortion service specification and post-abortion care guidelines (see case study 2). In Wigan, the local authority sexual health commissioner, also commissioning on behalf of the CCG, has responsibility for developing key performance indicators (see case study 7).

✓ *Seize opportunities for collaborative service development*

Wider collaboration

5.7.7 Build on public health activities to foster collaboration across commissioning organisations and services. In Northumberland, the public health department has seized the opportunities not only to work with other local government departments but also to collaborate with SARC services to address the needs of vulnerable adolescents. Linking SRH and HIV pathways to other areas of care, for example, alcohol drug, youth, maternity and mental health services, can reap benefits particularly in prevention (see case study 12).

Section 6. How to commission across pathways

6.1 This section:

- addresses areas of interface and overlap in commissioning of SRH and HIV services
- clarifies commissioning responsibility across pathways
- proposes possible local solutions to support commissioning of integrated pathways

6.2 There are a number of areas where commissioning responsibilities interface and overlap in SRH and HIV. These areas are highlighted in the following tables, which clarify where commissioning responsibility lies across care pathways. The tables also propose solutions that commissioners can discuss, develop, adopt or adapt locally to support commissioning of integrated pathways.

6.3 Although these interfaces may look complex at first sight, the level of detail is provided to ensure clarity of responsibilities. The principle that commissioners should adopt is:

- start with the patient and design a pathway that makes sense from the patient's perspective
- commission services to deliver that pathway
- collaborate with other commissioners – in different commissioning bodies or across boundaries – as required by the patient pathway
- ensure contractual arrangements for the commissioned services support the delivery of seamless pathways in the most effective and efficient manner

6.4 For example, rather than spending time and resource on working out detailed definitions of the 'sexual health' and 'non sexual health' elements of psychosexual services, it may be more productive for local authority and CCG commissioners to identify what psychosexual service is needed locally, agree to commission it and agree how the cost of the service is split; for example 50/50; 60/40 or similar. These arrangements can be reviewed as information on service use develops over time.

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Services shared between local authorities and CCGs

1. Psychosexual health services	2. Integrated abortion care pathway
<p>Sexual health aspects of psychosexual counselling (LA).</p> <p>Non-sexual health elements of psychosexual health services (CCGs).</p>	<p>Pregnancy testing, direct referral and support for self-referral to abortion care from SRH services (LAs).</p> <p>Abortion care including pre- and post-abortion counselling when needed (CCGs).</p> <p>STI testing and treatment, HIV testing, contraceptive advice and provision as part of abortion care pathway (CCGs).</p>
<p>Local solutions:</p> <p>Agree the service required.</p> <p>Design the pathway with referrals from SRH, gynaecology, alcohol, drug and mental health services.</p> <p>Agree the lead commissioner and commission the service.</p> <p>Split the cost and agree recharge/invoicing mechanisms.</p> <p>Monitor service usage and adjust split in costs over time if required.</p> <p>Where it is in the best interests of patients, commission from a single provider.</p>	<p>Local solutions:</p> <p>Agree an integrated abortion care pathway including contraceptive advice and provision, STI and HIV testing (taking account of the recommendations for young people in NICE PH51 guidance).</p> <p>Ensure pathways include referral back to SRH services where STI or HIV testing requires follow-up.</p> <p>Agree the lead commissioner and commission the integrated pathway/service.</p>

Local authorities and NHS England

NHS England and CCGs

3. SRH for people living with HIV (PLWH)	4. Cervical cytology
<p>Referral to specialist HIV outpatient services following diagnosis (LAs).</p> <p>Outpatient HIV specialist treatment and</p>	<p>Cervical screening programme delivered in a variety of settings including SRH services (NHS England).</p>

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<p>care (NHS England).</p> <p>Partner notification (PN) for contacts of people diagnosed as HIV-positive (LAs).</p> <p>STI testing for PLWH including routine screening (LAs).</p> <p>SRH advice and provision for HIV positive women (LAs).</p> <p>Contraception and sexual health advice and provision in general practice/public health screening for HIV positive women (NHS England).</p>	<p>Investigative cervical cytology in SRH or GUM clinics (CCGs).</p>
<p>Local solutions</p> <p>Commission management of HIV PN as secondary prevention in level 3 GUM clinics/integrated SRH clinics, with referral to specialised HIV services of partners diagnosed positive.</p> <p>Jointly ensure referral pathways are in place to meet the sexual health needs of PLWH post-diagnosis including routine STI screening at recommended intervals.</p> <p>Jointly ensure referral pathways are in place to meet the contraceptive needs of HIV positive women.</p>	<p>Local solutions</p> <p>Clarify local settings for screening programmes; NHS England to update CCGs on locations and providers.</p> <p>CCGs clarify with local providers arrangements for cervical cytology outside the national cervical screening programme.</p>

Services shared between all three commissioning bodies

5. HIV community-based support	6. SRH and HIV and maternity
<p>Community-based HIV clinical nurse specialists (CCGs).</p> <p>Hospital-based HIV clinical nurse specialists (NHS England).</p> <p>Psychosocial support for PLWH (LAs).</p>	<p>HIV physicians' referral to and liaison with maternity services for HIV positive women (NHS England).</p> <p>Maternity services' management of most complex pregnancies including those of HIV positive women (CCG).</p>

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Treatment information for PLWH (for local determination).	Contraception provided for contraceptive purposes in maternity services (LAs).
<p>Local solutions: CCGs and NHS England review the role of HIV clinical nurse specialists at a local level to ensure it is integrated with the pathway in the national service specification.</p> <p>LAs assess the contribution psychosocial support and treatment information make to the well-being of PLWH and to HIV prevention. LAs map patterns of service use to ensure funding follows the individual regardless of service location.</p>	<p>Local solutions : CCGs and NHS England commission services with agreed referral pathways and liaison between HIV out-patient and maternity services for HIV positive women.</p> <p>CCGs and LAs agree how contraception provided as part of the maternity services pathway is commissioned, for example commissioning lead and recharge/invoicing mechanisms.</p>

Services shared between all three commissioning bodies

7. HIV testing	8. Post-exposure prophylaxis (PEP) after occupational exposure to HIV and PEP after sexual exposure to HIV (PEPSE)
<p>In SRH and GUM clinics, and as part of local public health initiatives (LA).</p> <p>In A&E, acute medicine and other outpatient and inpatient settings for patients with HIV indicator conditions (CCG).</p> <p>In antenatal clinics (through the NHS Infectious Diseases in Pregnancy Screening Programme) (NHS England).</p> <p>In general practice (NHS England) except when commissioned as part of local public health initiatives eg offering to new registrants in high prevalence areas (LA).</p> <p>In termination of pregnancy services (CCGs)</p>	<p>Outside GUM clinic hours initiation of PEP/PEPSE in A&E departments (CCG).</p> <p>Initiation of PEP in Occupational Health services (CCG).</p> <p>Initiation and ongoing management of PEPSE in Level 3 GUM clinics (LA).</p> <p>Initiation of PEPSE in other SRH services with referral to Level 3 GUM clinics for ongoing management (LA).</p> <p>Antiretroviral drug costs for PEP/PEPSE (NHS England).</p> <p>Health promotion campaigns (LA).</p>

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<p>HIV testing in other non-traditional settings – community, outreach, home sampling (LA).</p>	
<p>Local solutions: Collaborate to ensure expanded HIV testing is in all relevant service specifications and no aspect is omitted.</p> <p>Ensure there are referral pathways in place to HIV specialised services from all testing sites.</p> <p>Jointly monitor impact on number of people presenting with HIV at a late stage of infection.</p>	<p>Local solutions: Include PEP/PEPSE in specifications for SRH services, GUM clinics and A&E departments with clear referral pathways.</p> <p>Commission publicity for the availability of PEPSE in targeted community health promotion campaigns.</p> <p>Work together across all 3 commissioning organisations to monitor PEP/PEPSE activity locally, ensuring completion of courses and planning behaviour change interventions as required.</p>

Services shared between all three commissioning bodies

<p>9. Contraception for contraceptive and non-contraceptive purposes</p>	<p>10. Pathology services as part of SRH or HIV treatment and care</p>
<p>Gynaecology including any use of contraception for solely non-contraceptive purposes eg fitting of intra-uterine system (IUS) for heavy menstrual bleeding (CCG).</p> <p>Contraception provided solely for non-contraceptive purposes in general practice. (NHS England).</p> <p>Contraception for contraceptive purposes outside the GP contract (LA).</p> <p>Contraception for contraceptive purposes provided as an additional service under GP contracts (GMS, PMS and APMS) (NHS England).</p>	<p>Pathology services associated with STI testing, diagnosis and management provided in SRH and abortion services but excluding areas covered below (LAs).</p> <p>Pathology services associated with HIV testing (LAs/CCGs/NHSE).</p> <p>Pathology services associated with HIV treatment and care (NHS England).</p> <p>Pathology services associated with infectious diseases in pregnancy screening and cervical screening (NHS England).</p>

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<p>Local solutions</p> <p>CCG develops the pathway for contraception for non-contraceptive purposes jointly with the LA as commissioner of SRH services including contraceptive services.</p> <p>Consider the option of the LA commissioning this activity and recharging the CCG. This could facilitate consistent standards and price harmonisation across SRH and gynaecology services.</p> <p>Specify jointly the competence level required to fit IUS in LA, CCG and NHS England commissioned services.</p> <p>Maintain the expertise of those fitting IUS for both contraceptive and non-contraceptive purposes.</p>	<p>Local solutions</p> <p>Agree a common approach to quality standards for diagnostics and laboratory services to ensure consistency across care pathways in SRH and HIV services.</p> <p>Map the pathology services used by providers. When tendering, where SRH or HIV forms a significant percentage of a pathology service's workload, assess the potential risk of destabilisation of pathology provision and the impact on other services. Advise and involve other commissioners at an early stage.</p>
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Services shared between all three commissioning bodies

11. Sexual assault referral centres (SARCs)

Assessment, emergency contraception and referral of individuals who have experienced sexual assault from sexual health services to SARCs (LA).

Sexual health screening, PEPSE and emergency contraception in SARCs (NHS England).

STI management on referral from SARCs (LA).

Abortion on referral from SARCs (CCGs).

HIV treatment and care on referral from SARCs (NHS England).

Local solutions:

Undertake joint needs assessment on sexual violence to vulnerable adults, men, women, adolescents and children by LA public health departments and NHS England health and justice teams.

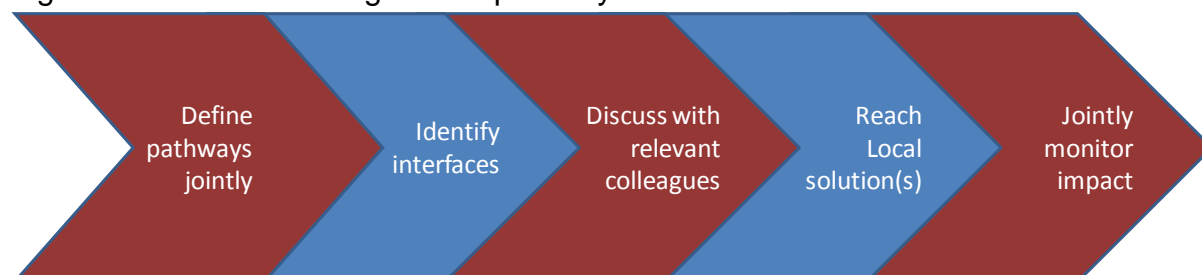
Set up a joint sub-group of the HWB with public health and children's services, CCGs and NHS England health and justice and specialised services commissioners to define local pathways with clear referral routes and follow-up between SARCs and SRH, GUM, HIV, abortion and LA social services. Address the needs of adolescents and children.

Commission and collaboratively performance manage based on the agreed pathways.

Specify in LA contracts that integrated SRH or GUM services should refer to and work with SARCs and provide STI and PEPSE management to patients based on specified referral pathways from SARCs.

Specify SARC referral pathways to GUM, SRH and abortion services in NHS England pathways.

The actions required to commission across pathways are summarised in figure 10. Figure 10. Commissioning across pathways



Case studies

Case study 1: Joined up commissioning of sexual and reproductive health services – including abortion – to seamlessly manage supply and demand

NHS Kingston Clinical Commissioning Group (in shadow with its former PCT) and the Royal Borough of Kingston upon Thames agreed to establish a single lead commissioner for sexual and reproductive health between them, based in the local authority. When recruiting to this senior joint post, they agreed to appoint a “traditional” commissioner, that is someone without a core/qualified public health or clinical background.

Both the local authority and the CCG agreed to retain their own sovereignty – the organisations pay for their responsible services from their own budgets (there is no pooled resource) with the lead commissioner operating under both organisations’ rules and processes – yet from a single set of principles which had been developed by both groups.

Results

In year one the following has been achieved:

- a single, networked approach to delivering services across the borough has been maintained incorporating all providers
- a ‘same principles’ approach to pricing and service activity plans has been applied, driving efficiency savings in both CCG and local authority-funded services
- a ‘whole system’ review plan has been agreed for 2014-15, which will see both the CCG and local authority-funded services be part of a single mapping, gap analysis, redesign and full stakeholder consultation process
- further efficiencies/productivity savings have been identified across providers for 2014-15

Contact details

Peter Taylor, Lead Commissioner, Sexual & Reproductive Health, Royal Borough of Kingston and NHS Kingston CCG

Email: peter.taylor@kingston.gov.uk

Case study 2: How a strong sexual health network has successfully managed the changes to the commissioning process

Greater Manchester Sexual Health Network serves a population of 3 million, including 10 local councils, 12 clinical commissioning groups and 8 acute trusts. The network brings together commissioners and providers of sexual health services including HIV to support collaborative working, recognising a whole system partnership approach is essential to improving outcomes. It now reports to the directors of public health.

Sexual health commissioning leads meet every 6 weeks. Commissioners from the 10 local authorities, the lead CCG for abortion services and NHS England are members of this group. In addition to the formal meetings, sexual health commissioners meet to discuss practical issues in more detail, such as developing service specifications. The network has facilitated partnership working between sexual health commissioners in Greater Manchester for 10 years.

Several collaborative commissioning arrangements have been in place for many years where areas are part of multi-lateral contracts or using Greater Manchester service specifications. This includes the Greater Manchester chlamydia screening programme, a central booking service for abortions, multi-lateral abortion contracts, sperm washing guidelines for people living with HIV, locally commissioned services for pharmacy provision- service specification and training, condom distribution, integrated sexual health and young person's sexual health service specifications. These arrangements have increased quality, ensured consistency in services across all areas and been cost effective. Following transition, local authorities and CCGs have agreed to continue the collaborative contract arrangements established by the PCTs.

Results

The directors of public health have asked the network to continue and further develop the collaborative commissioning arrangements. These arrangements ensure services provide value for money, make best use of skills, expertise and resources and secure the efficiencies of a larger footprint but remain sensitive to local needs.

Local authority commissioners are keen to work with NHS England's Area Team (AT) to ensure integrated services provide HIV treatment as well as sexual healthcare and contraception and that clear pathways and funding arrangements are in place. It is hoped the relationship and links between local authorities and NHS England ATs will continue to strengthen as time progresses.

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The Network recognises good working relationships between sexual health commissioners and providers are essential to inform the commissioning processes. Priority Action Groups give an opportunity for commissioners and providers to work together to drive forward actions across Greater Manchester on particular topics, for example, prevention, young people and abortion.

Contact details

Sarah Doran, Interim Director, Greater Manchester Sexual Health Network
Email: sarah.doran@tameside.gov.uk

Case study 3: Using the scrutiny process to focus on HIV prevention

Health in Hackney Scrutiny Commission undertook a scrutiny review focusing on “Controlling the transmission of HIV”. The main driver was the fact that slower progress was being made on HIV than on the other two top priorities which the Council is obliged to address in the public health outcomes framework.

Diagnosed HIV prevalence in the UK is 2 per 1000 of the population. In Hackney it is 7.4 per 1000, one of the highest in London. Hackney faces increases in new and recent infections (predominantly among MSM) and a problem of late presentation of HIV (predominantly among Black African residents).

The Commission’s review aimed to answer the following core questions:

- how are commissioners and providers in Hackney responding to the continued high prevalence of HIV?
- who is accessing services and who is being targeted by prevention programmes and how can both of these activities be optimised?
- what steps are being taken to prepare for increased financial constraints on the funding for HIV prevention and treatment and the potentially higher burden on adult social care services as some survivors who live longer might require ongoing services?
- how can the public health message about the need to reduce risk-taking behaviours be best disseminated in a very diverse borough?

The review took evidence from a wide range of stakeholders including the council's public health service, local sexual health services and third sector providers working with people living with HIV in the locally affected communities.

As well as using desk research and inviting written submissions, the scrutiny commission made local site visits and benchmarking visits to service providers outside the borough including Positive East and Chelsea and Westminster Hospital NHS Foundation Trust’s 56 Dean St clinic.

Results

The scrutiny process gave members the opportunity to raise questions, review key issues and deepen their understanding of the context in which the council is commissioning sexual health services. The need to better align and rationalise funding streams, at least locally, to make them more transparent and to eliminate perverse incentives in the system, emerged as a key theme. The Commission's report in April 2014 made ten recommendations focusing on funding arrangements for HIV prevention and support, alignment between local and pan-London prevention activities, the role of voluntary organisations, GP practices and local faith leaders in prevention and support, sex and relationships education, prevention approaches such as home sampling, home testing, rapid access and express testing services, and training to avoid accidental disclosure. The review helped build understanding and relationships which will be useful as recommendations feed into planning in an increasingly challenged funding context.

Contact details

Jarlath O'Connell, Overview and Scrutiny Officer, Hackney Council.
Email: jarlath.oconnell@hackney.gov.uk

Case study 4: How clinical senates are a critical friend of the system

The South West Clinical Senate was asked by the specialised commissioners, South West, to provide advice on HIV care across the region. Clinical senates provide strategic advice to commissioners to support effective decisions and build professional consensus.

The following question was addressed:

Given the demography of the South West, what would the Senate consider to be the optimal model/s to deliver HIV care to children and adults with specific reference to:

- 24/7 access to specialist opinion
- the issue of late diagnosis
- people over 50 years of age

The South West Senate Council, composed of clinicians from across the South West, is the body responsible for deliberating on questions raised by commissioners. The meeting on HIV was held in two parts, hearing evidence about service provision from expert witnesses including a member of the National Clinical Reference Group for HIV, two senior consultants caring for adults and children respectively, PHE, a Bristol University expert in the distribution of HIV and the Terrence Higgins Trust. Having heard the evidence, Senate Council members discussed options for services,

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including how to address the continued issue of stigma and the provision of HIV services for children.

Results

The service specification for the specialised HIV pathway requires the availability 24/7 of expert consultant advice for patients who might be admitted to hospital with acute manifestations or complications. The prevalence of patients living with HIV, which is skewed towards the two large urban conurbations in the South West, Bristol and Plymouth, makes the provision of 24/7 services particularly challenging. Neither area is able to comply with the requirements of the specification.

The South West Senate had previously described the principles which should be applied when considering the implementation of specialised service requirements and, using these, arrived at its decision in support of the establishment of a single South West HIV provider network for adults living with HIV with two hubs each providing 24/7 specialist opinion. In addition to specific advice on the issues raised by specialised commissioners, including children's services, testing and changes in age-related prevalence, the Senate commented on training and social care needs of people living with HIV.

Full details of the process, advice and evidence used to arrive at the decision are available on the South West Senate website: www.swsenate.org.uk

Contact details

Sunita Berry, Associate Director, South West Strategic Clinical Network and Senate. Email: sunita.berry1@nhs.net

Case study 5: Six local authorities agree a collaborative approach to public health and commissioning sexual and reproductive health services

Six local authorities in Berkshire (Slough, Reading, Bracknell Forest, West Berkshire, Royal Borough of Windsor & Maidenhead and Wokingham Borough Councils) established a legal agreement to share resources to commission sexual and reproductive health services. A jointly appointed Director of Public Health for Berkshire leads a shared team.

The key commissioning aims are to ensure equity of access for service users and an efficient use of public health resources. The approach is based on pooling resources, concentrating expertise and developing a countywide approach. It also facilitates liaison with the commissioners of HIV treatment and care and abortion services.

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Berkshire has two main sexual health service providers: one acute and one community-based.

The key features of Berkshire's approach to commissioning of sexual and reproductive health services are:

- commitment of the six councils to work together and the development of a legal agreement
- oversight of all public health commissioning by an advisory board at senior level (director or above)
- a programmatic approach with funding allocated to a programme lead
- identification of a lead consultant in health protection
- establishment of a multi-local authority sexual health procurement steering group
- completion of a needs assessment to ensure commissioning is sensitive to local variation.

Stakeholder engagement was through six locally-focused events including providers, councillors, CCGs and charities. Representatives of vulnerable groups were invited to a pan-Berkshire event. Commissioners plan to use the national sexual health specification supplemented by local needs assessment. A clinical reference group will sign off standards for the specification developed with local clinicians. The final version will be externally reviewed to avoid any conflict of interest. BASHH has been approached for a recommendation.

Results

Having a shared team allows a “do it once and share” approach and ensures quality standards are consistent and monitored across the region. Pooling of funding gives flexibility to address equity of service provision and manage risk. A shared team helps commissioning from general practice and community pharmacists; allowing a consistent approach to contracts and ensuring local ownership. Having a single point of contact gives all providers one consistent access point. It also improves co-ordination with NHS England and local CCGs, helping reduce gaps in service.

The local authorities maintain overall oversight and responsibility. Papers are routinely presented at the six health and wellbeing boards with councillor briefing as required. The joint Advisory Board receives regular update reports. These are closely scrutinised at the sub-group of the public health consultants and finance leads for each council.

Contact details

Nicola Gurr, Contracts Manager, Bracknell Forest Borough Council

Email: nicola.gurr@bracknell-forest.gov.uk

Case study 6: Building on a joint service redesign to develop commissioning in the new landscape

Integrated sexual health services and HIV treatment and care in Hampshire are now commissioned by three local authorities, seven CCGs and the NHS England Area Team. This follows a project initiated in 2009 by sexual health leads in Hampshire's public health team to redesign and integrate local sexual health services to meet identified needs.

That project led to procurement of a consultant-led hub & spoke integrated sexual health service, which has been operational since January 2012 in more than 20 clinic locations with a single point of access for residents of all three local authorities. The service model includes HIV outpatient care, STI testing and treatment, contraception, abortion, vasectomy, psychosexual counselling, chlamydia screening and sexual health promotion services plus a training and network management function for community pharmacies and GPs. Outreach clinics in FE colleges and an outreach referral service for vulnerable young people are also provided. £1m was saved in the first year of operation.

Commissioners have responded to the new commissioning landscape by continuing to meet to review the service collectively. They have also developed and agreed terms of reference including an information sharing protocol to enable activity, finance and performance information to be shared across all commissioning organisations.

The commissioners now use a range of integrated sexual health currencies and tariffs. Each commissioning organisation is responsible for paying for its own activity and either has a contract for the service in place or acts as an associate to a lead CCG or local authority public health contract. The integrated sexual health service has an overarching service specification and quality outcomes framework. The specification includes cross references to the national service specification for HIV services held by NHS England. Individual commissioning organisations can edit the overarching specification if required for their own contracts. Abortion services are covered by the integrated services specification. HIV treatment and care is commissioned by the NHS England specialised services commissioning area team. Contract and performance management by the local authorities and CCGs is undertaken collaboratively with support from integrated CCG & LA commissioning units, where these exist, and the local commissioning support unit. Commissioners hold a joint pre-meeting prior to quarterly service review meetings.

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The information sharing protocol supports service-wide activity and performance monitoring across all commissioning organisations (local authorities, CCGs and NHS England). Local authority contract end dates have been aligned. Plans are now being developed to review the service model in line with updated sexual health needs assessments and local practitioner and public engagement. The findings of the review will inform current discussions on collaborative commissioning and procurement in the near future.

Contact details

Rob Carroll, Public Health Manager, Hampshire County Council

E-mail: robert.carroll@hants.gov.uk

Case study 7: A CCG gives the lead to the local authority to commission abortion services

An Integrated Commissioning Team for Child Health has been in place since 2009, with senior joint posts sitting across the former PCT (subsequently Wigan Borough CCG) and Wigan Council. Pooled and aligned budgets are utilised by the team to commission effectively against the needs of the population.

Commissioning responsibilities extended from Children & Young People to the whole life-course in 2012. Working practices had been in place for a year when the national transition of sexual health commissioning responsibilities from Wigan Borough CCG to Wigan Council took place in April 2013. In Wigan Borough the Integrated Commissioning Team remained as lead commissioners for this work.

The Wigan Health and Wellbeing Board promotes integrated working. This helped to create a seamless transition to the new commissioning arrangements. Wigan Borough's ambition is to design integrated sexual health services around the patient.

The Sexual Health Lead Commissioner (SHLC) for Wigan Council is already an established member of the Greater Manchester Sexual Health Network. The Network had, through collaborative working and commissioning, greatly improved the client experience of abortion services across Greater Manchester over the past decade and delivered significant cost savings.

There are Greater Manchester-wide multi-lateral contracts in place for independent sector providers, with Central Manchester CCG as the lead organisation for the collaborative commissioning arrangements. This provides a role model for Wigan.

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Working on behalf of Wigan CCG (which has overall responsibility for commissioning and funding abortion services), the SHLC for Wigan Council leads commissioning of abortion services. These services are delivered by independent sector providers and include the abortion central booking and BPAS abortion services.

The SHLC has responsibility for developing the service specification including key performance indicators and tariffs, which are adapted from the Greater Manchester Sexual Health Network abortion service specification and post-abortion care guidelines. The CCG has responsibility for contract functions including sign-off.

Results

The SHLC deals with service delivery issues and leads on quarterly contract performance meetings, with representatives from Wigan CCG contracts and finance departments attending.

The SHLC feeds into the CCG via the Wigan Council Start Well Service Manager with portfolio responsibility for sexual health.

Service invoices are submitted to the SHLC and CCG Finance which arranges payment.

Significant savings to the CCG have been realised since the collaborative commissioning arrangements began, with improvements in treatment under 10 weeks, non-attendance (DNA) rates and uptake of long-acting reversible contraception.

Contact details

Eleanor Mansell, Sexual Health Lead Commissioner, Start Well, People Directorate, Wigan Council Email: e.mansell@wigan.gov.uk

Case study 8: Collaborative commissioning of genitourinary medicine (GUM) services in NW London

High and increasing rates of STIs and HIV, with a highly mobile population including commuters and other visitors, mean that demand for GUM services is high in London. The open access requirement for sexual health services means commissioners are working with many providers across the capital.

Nine local authorities in NW London (Barnet, Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster) came together (prior to the transition of sexual health commissioning to local authorities) to collaboratively commission GUM services.

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The following benefits of collaboration were identified:

- contracts could be placed with individual providers covering multiple local authorities. Collaboration has reduced the potential number of contracts from 48 to six
- key performance and quality indicators were agreed for the service specification. This ensures consistent standards of service delivery for users attending any of the contracted providers
- negotiations with providers began based on higher volumes of activity than could be achieved by any local authority independently. For commissioners, facing a new imperative of paying for services within a fixed grant, this became important to continuing to seek efficiencies across the system. For providers, having a predictable financial position for a sizeable proportion of their overall activity should result in some planning stability at a time of major change

The nine local authorities were required to ensure collaborative commissioning was agreed within their own governance structures. This required presentation of the collaborative principles and structure to either a lead cabinet member for public health, the leader of the council or to cabinets. The process of securing the necessary agreements was often lengthy.

Some of the participating authorities required a procurement waiver be put in place. This was necessary to ensure contracts for GUM services could be placed with providers without undertaking an open procurement process.

Legal documents required included a collaboration agreement. This described and defined the relationships, roles and responsibilities of each authority within the collaborative.

The agreed principles and the legal documentation defined that the host borough for any given provider would lead on contract negotiations on behalf of itself and the other authorities. The negotiation would be conducted according to the agreements reached by commissioners on specification, indicators and pricing. Each authority remained in communication with the others if any of these was not agreed by the provider. The host borough is ultimately responsible for placing the contract with the provider.

Results

The collaborative approach with performance and quality indicators included in the common service specifications has led to a more consistent approach to service delivery and streamlined the commissioning process. In addition, the approach will

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aid discussion on implementation of the integrated sexual and reproductive health tariff.

Lessons learnt may inform the approach to any future open procurement. In the first year, much has been learned by commissioners and providers. Not all the aims have been fully achieved. However, the principles have been recognised as solid, and the intent is to continue. In 2014/15, a further three local authorities are joining the collaboration.

Contact details

Ewan Jenkins, Sexual Health Commissioner, Tri-Borough Public Health Service, Westminster City Council. Email: ejenkins@westminster.gov.uk

Case study 9: Sharing responsibility along the sexual health and HIV pathway

Sharing commissioning responsibility along the sexual health and HIV pathway provides a number of opportunities to address the holistic needs of people living with HIV and the wider public health agenda. As well as potential benefits, there are also some challenges. Without a collaborative approach between NHS England, local authorities and CCGs, there were concerns the sustainability of HIV care and treatment services could be at risk. These are generally integrated with GUM bringing benefits of shared workforce, clinical skills, training, laboratory services and premises.

Although traditions of joint working or commissioning exist in other service areas, such arrangements are under-developed in HIV. From an NHS England perspective, HIV commissioning represented a new area for many and previous experience varied. ATs hold provider contracts for a portfolio of over 100 service specifications and in areas of low HIV prevalence, this represented a small area of focus. However, HIV has become a significant area of focus across all ATs due to:

- the service specification exercise which showed the need for greater formalisation of network arrangements in HIV care and treatment
- tendering of GUM services in local areas and the need to agree how HIV services should be dealt with in the context of tenders.

NHS England recognised a potential risk to HIV services and agreed a set of practical actions for AT implementation. ATs were asked to:

- a) identify a named point of contact for HIV specialised commissioning in the Area Team (specialised commissioning hub) and ensure they had made contact with the leads for sexual health commissioning in the relevant local authorities

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- b) identify any activity or contracts not yet transferred to NHS England
- c) identify the currency and pricing arrangements of existing contracts and the elements of service covered. This will support the forthcoming pricing work on the national HIV outpatient tariff
- d) identify and act on any immediate risks to HIV service provision to ensure there is no deterioration in service
- e) ensure NHS England involvement in any sexual health tendering process especially where current provision is integrated GUM and HIV
- f) promote patient and public engagement in any changes in provider configurations

The HIV Clinical Reference Group (CRG) and Accountable Commissioner provide additional support to the Area Teams in terms of:

- a) access to CRG-wide and local clinicians who can provide service delivery intelligence
- b) templates for data collection regarding provider landscape and contracts to help with mapping
- c) facilitating links to local authority commissioning leads, Local Government Association and PHE Centre leads

Results

HIV has become an increasing area of priority for NHS England which has a duty to commission HIV care and treatment services. To do this NHS England needs to work collaboratively given the HIV pathway of diagnosis and treatment and the new commissioning arrangements. As a national organisation with a single operating model, its communication to ATs aimed to ensure a nationally consistent approach to tackling this issue.

ATs, local authorities, and PHE are continuing to make links, share information and work together to deliver their individual and shared responsibilities around sexual health and HIV.

Contact details

Claire Foreman, Programme of Care Lead for Cancer & Blood, NHS England (London Region) and Accountable Commissioner for HIV CRG

Email: claireforeman@nhs.net

Case study 10: Three local authorities use a time of change to create an integrated sexual and reproductive health service

Leicester City Council and Leicestershire and Rutland Councils re-commissioned sexual and reproductive health services. This was precipitated by two previous providers giving notice in 2012.

The public health leads wanted to develop and procure an integrated sexual and reproductive health service from levels 1-3 including a youth sexual health service and chlamydia screening, with the introduction of an integrated sexual health tariff to generate cost savings. They aimed to maintain clinical engagement and involve local authority finance, legal and procurement departments, during the transition to the current commissioning arrangements.

A local clinical engagement group was set up with clinicians in GUM and contraceptive services, GPs with an interest in sexual health, and nurses in primary and secondary care. This group developed the model at meetings facilitated by clinical and non-clinical external facilitators, provided by MEDFASH, to ensure credibility with local professionals and impartiality.

A programme board was established, chaired by public health, with the three local authorities responsible for commissioning from April 2013, who agreed a joint commissioning approach. The programme steering group's local authority representatives each led on legal, finance or procurement issues. The service specification, based on the proposed model, was developed with an external clinician to maintain the integrity of the procurement process.

The Local Education and Training Board (LETB) was involved in developing the specification ensuring a requirement for the new provider(s) to continue specialist registrar training in GUM and Community Sexual and Reproductive Health. Public health leads worked to ensure all governance processes in the local authorities were completed; providing briefings and papers to secure approvals for procurement to proceed.

The Greater East Midlands Commissioning Unit led on the procurement process. The tender selection was undertaken by a team including the LETB and an external clinician. Once a new provider was selected, a mobilisation group and work streams were established to ensure a safe transition. The group had to deal with TUPE, assets, building, IT and data issue.

Results

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The public health leads, now local authority employees, continue to work with the new provider to fully mobilise the service including the shared IT database for sexual and HIV services. They also liaise with CCG and NHS England colleagues to ensure the agreed pathways between their commissioned SRH services and services such as abortion, vasectomy and HIV treatment and care are working effectively.

Contact details

Liz Rodrigo, Public Health, Leicester City Council. Email:

liz.rodrido@leicester.gov.uk

Janet Hutchins, Public Health, Leicestershire County Council & Rutland County Council. Email: janet.hutchins@leics.gov.uk

Case study 11: Using contracting tools to safeguard future training and education and the workforce

Oxfordshire County Council's aim was to commission an integrated sexual health service that safeguarded training provision. They recognised that training for all those involved in the delivery of sexual health services was vital to protecting the future workforce – as well as being an indicator of quality of service and patient care. The Public Health Commissioning Team used different ways of ensuring the commissioning process included training, education and workforce issues. This was achieved through consultation, assessing need and developing the workforce aspects of the specification.

From the outset, Oxfordshire developed a service specification in line with national guidance. They consulted with many partners and stakeholders including local academic and training institutions using professional and expert opinion to develop a service specification that embedded training as a key component.

The specification and tender process required any provider who bid for the contract to:

- be an approved training location
- demonstrate how they proposed to train all those providing sexual health services, not just the staff employed by the provider
- deliver training to national standards as set out in the specification
- specify how they would report training activity on a monthly basis

The commissioning of the integrated service followed Oxfordshire County Council's procurement processes. Commitment to procuring the new service was approved by the Cabinet member for Public Health and commissioners provided updates to Oxfordshire's Public Health Governance Committee throughout the tendering process.

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Results

To ensure that commitment to sustainable training and education was understood by potential providers, service bidders were asked to describe how they would ensure all staff have appropriate skills and qualifications for the future and how they would provide monthly monitoring activity as part of the tendering process.

Oxfordshire County Council believe having a suitably trained workforce to deliver a quality service will be attractive to future employees which will be a boost to the local economy.

In the future, those commissioning sexual health services should consider working with LETBs to ensure that training programmes are developed collaboratively to be fully integrated into future services.

Contact details

Eunan O'Neill, Consultant Public Health, Oxfordshire County Council,
Email: eunan.oneill@oxfordshire.gov.uk

Case study 12: A public health department collaborates to reach vulnerable adolescents

Using cross-organisational working to promote sexual health, Northumberland County Council's public health department is able to reach vulnerable young people to help achieve the following objectives:

- an increase in the uptake of sexual health screening
- signposting and referrals to sexual health and other services
- dissemination of health promotion messages

Interventions have been jointly agreed and commissioned to embed this approach, which include:

- a health and wellbeing service (part delivered by council employees and part through an NHS health improvement partnership arrangement) providing teacher training on Sex and Relationships Education (SRE) and drugs and alcohol health promotion in targeted schools. This includes promoting awareness about sexual assault through sessions delivered by the SARC Health Care Professionals
- sexual health service staff promoting breastfeeding and midwives having a pathway of referral to the sexual health service. The contract includes targeted work with teenage mothers, aiming to increase contraception uptake by taking services such as LARC provision to clients in their homes. This includes implant insertion, injectable methods, condom promotion, and holistic health information and guidance on breast feeding and alcohol consumption

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- the targeted adolescence team and Sure Start Children's Centres providing brief health promotion intervention, offering chlamydia screening and signposting to emergency contraception at pharmacies, sexual health services and LARC methods
- the school health service delivering universal SRE in Year 5 and Year 8 and signposting to the community sexual health sessions delivered weekly in 13 secondary schools. They offer a range of contraceptive methods, asymptomatic screening for STIs and referrals to additional services such as termination, pregnancy support and advice
- targeted work on risk taking behaviour includes drugs and alcohol awareness, additional SRE and external agency visits e.g. SARC awareness sessions

This commissioned work was informed by sexual health and sexual violence needs assessments with outcomes identified in the sexual health, school nursing & health improvement service specifications. It illustrates a commissioning approach which identifies all key players with a dedicated member of staff supporting and monitoring the NHS providers as well as a Health and Wellbeing Team within the council. This approach facilitates a well-respected partnership arrangement.

Results

Future plans for a more whole system approach include a draft service specification to ensure that public health outcomes are included within the work of targeted adolescent services, including youth offending teams, drugs and alcohol services and people working with looked after children. Chlamydia screening, clear pathways and signposting to dedicated health advisers for particularly vulnerable young people are being developed in partnership with Sure Start Children's Centres. In this way, the pathways to sexual health services are made the responsibility of all services working with vulnerable young people.

Contact details

Karen Herne, Public Health Service Manager, Northumberland County Council
Email: karen.herne@northumberland.gcsx.gov.uk

Case study 13: A multi-agency steering group maintains momentum in reducing teenage pregnancies

Darlington local authority has a multi-agency teenage pregnancy and sexual health steering group. The group's work feeds into commissioning of sexual health services and also involves a wider professional stakeholder network.

The director of public health chairs the steering group which is co-ordinated by a member of the public health commissioning team. Membership of the group is broad

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including local authority children's commissioners and service leads, sexual health services, midwifery, health visiting, academies, colleges and voluntary sector organisations. A number of organisations, including the CCG and NHS England area team, are part of the wider professional stakeholder network.

The steering group is not a contracts or provider-commissioner meeting but rather a forum for partners to share updates on their activities which acts as a springboard for wider work. Partners are able to raise key service issues and any urgent matters are addressed by task and finish groups. The group also provides an effective forum for sharing 'soft' intelligence which is a vital addition to the data provided outside the group through contracting meetings. It is an effective channel for public health commissioners to present updates on policy, data and priorities. For example the group has reviewed CCG locality data on terminations of pregnancy.

The group has a detailed delivery plan incorporating local and national public health priorities. A priority in the plan is to review care pathways including a teenage pregnancy pathway which has been agreed by the group linking health, social care and education.

Results

Following the steering group's first stakeholder event, attended by professionals, young parents and young people from local academies and colleges, separate interactive young people's events were requested. Young people were involved in planning the format of these events which yielded valuable feedback on services. They also led to a formal consultation group of 30 young people being established who are now being consulted as part of sexual health service reviews.

The council's cabinet member for children and young people has been a keynote speaker at the professional stakeholder events. Outcomes from engagement have been actively followed up by the steering group and are reported by the DPH to the Children and Young People's Collective, and the Health and Wellbeing board via the Cabinet member for health and partnerships.

The steering group supports the discussion of new ideas and helps foster innovation and collaborative working. An example is a small non-recurring fund launched to pilot innovative ideas. Applications were received from voluntary organisations and teenage parents supported by a member of staff. The steering group will review the outcomes of these projects and two young parents have presented their experience of the grant funded project at the professional stakeholder event. The group has also recently reviewed local social norms data via a healthy behaviours survey completed in academies and made recommendations on how to develop the sexual health section further.

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The engagement networks established will feed into service review mechanisms forming part of the commissioning process. Discussions have commenced with Healthwatch, the local youth partnership supported by Darlington's Youth MP and the PSHE network, to map engagement and ensure a broad range of approaches and sectors are included in consultation on service development.

Darlington's experience emphasises the importance of leadership on tackling teenage pregnancy, working across council service areas and having designated points of contact from partner organisations. The steering group promotes engagement with professionals and young people and provides a focus for consultation with external agencies feeding into public health commissioning.

Contact details

Nathalie Carter, Public Health Practitioner, Darlington Borough Council
Email: Nathalie.Carter@darlington.gov.uk

Case study 14: "Positive Steps into Work" – working across local government to support People Living with HIV to find employment

"Positive Steps into Work", Blackpool Council's employment support service, was set up in 2007. Since its inception it has served different client groups, including Blackpool residents in the most disadvantaged areas of the town (Lower Layer Super Output Area's (LSOA) 20% most deprived wards). The delivery team are experienced in working with diverse clients with complex needs.

Working in partnership with public health, the service has developed a dedicated employment adviser post exclusively to support clients from the Council funded substance misuse service (Recovery Centre) and HIV support programme (Sexual Health HIV Education and Response - SHIVER). Clients are offered personalised employment support and access to the wider service which includes work placements, online job search workshops, access to training, CV writing and application support, and interview skills training. The employment adviser can support customers with back to work costs such as interview/work clothes, transport, childcare costs and work equipment. This funding is essential in overcoming barriers to work for many long-term unemployed clients.

The service is built on the premise that employment support is a specialist skills set and is therefore best provided by those able to give good quality information, advice and guidance with understanding of the local labour market, rather than being an add-on to the role of "key workers" in health-related agencies. In this way, support to enter or return to employment or training is tackled independently from clients' other

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support needs. This allows workers to focus solely on the client's barriers to employment without becoming enmeshed in other areas of their lives.

The employment adviser is centrally located at the Positive Steps into Work service within easy walking distance of the Recovery Centre and SHIVER. Initial client appointments take place in either partner's centre but subsequent appointments are often made in the centrally located employment centre with access to confidential interview space, a training room and ICT suite for job search, group workshop sessions and regular drop-in sessions such as the Money Advice Service, National Careers Service and the Wellness Service (health trainers and health MOT team).

This begins the process of moving clients onto a more mainstream offer integrating them with other job seekers. The employment brokerage service encourages local employers to access the large pool of unemployed residents in the town by offering work trials, basic training, pre-employment schemes and local recruitment events.

Results

The new service began in November 2013. Initial indicators suggest it is providing valuable support to clients who would not otherwise have accessed specialist employment advice.

To date from a caseload of 48 clients, two with complex needs have been supported into paid employment with others in the pipeline, 17 have received additional support from the National Careers Service, 19 have been referred into the work placement programme (Chance2shine), three have been referred to volunteering services, two to training and three to wider support services.

Contact details

Judith Mills, Senior Public Health Specialist, Blackpool Council,
Email: judith.mills@blackpool.gov.uk

Case study 15: The English Sexual Health and HIV Commissioners Group (ESHHCG) shares experience and disseminates knowledge

The ESHHCG is a commissioner-only network, which reduces the isolation of the sexual health commissioner role, highlights good practice, enhances national consistency and helps maintain the profile of sexual and reproductive health and HIV. Its work supports the development of collaborative commissioning to promote high quality and cost-effective local decision-making.

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The group's aim is to support commissioners in improving population and patient-level outcomes in sexual health and HIV by sharing information, challenges, ideas and models of good practice.

The group also:

- responds to the commissioning environment in which local authorities, CCGs and NHS England share responsibility
- supports those new to sexual health and to commissioning
- ensures key policy is disseminated and understood by commissioners
- acts as an expert reference group, supporting practical policy development across the system.

The group's co-chaired elected executive is responsible for setting future direction and the content and structure of meetings. The executive members are also charged with being the representatives for their region. It has three non-voting members. To further its aims the co-chairs hold additional roles; representing the group on other bodies such as the Department of Health's Sexual Health and HIV Forum.

Funded by PHE, the group's secretariat function is provided by the National AIDS Trust (NAT). The group comprises over 200 members. More than 60 attend the meetings held three times a year. An interactive online notice board allows individual commissioners to pose queries, work through shared solutions and debate current and emerging issues. It has a facility to upload documents, such as service specifications or audits.

Results

The group's success is due to the support of the previous and current executive, members and NAT. It runs on the input of members and is not an official decision-making forum. It is largely made up of local authority commissioners, though all commissioners of sexual and reproductive health and HIV are encouraged to participate. It is unique, in being a commissioner-only space.

At meetings, commissioners provide updates on new or emerging agendas, work through current challenges and develop shared solutions. Time is allotted for clinical and other colleagues in the field to make presentations and engage with the group. The Department of Health (previous funder of the group) and PHE (the current funder) provide updates. Policy updates are also received from MEDFASH and NAT. Commissioners report on developments of interest.

Achievements to date include the shared authorship of a number of publications with PHE, the Local Government Association and Department of Health.

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Contact details

Claire Foreman, Co-chair, Senior Service Specialist / Regional Programme of Care Lead – Cancer & Blood (London Region), NHS England

Email: claireforeman@nhs.net

Jackie Routledge, Co-chair

Public Health Specialist Commissioning Sexual Health, Lancashire County Council

Email: jackie.routledge@lancashire.gov.uk

Annex 1. Guidance, tools and resources for whole system commissioning of sexual and reproductive health and HIV services

Policy, guidance and advice documents

1. Department of Health. A framework for sexual health improvement in England. 2013. <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england> Accessed on: 14/04/2014.
2. Local Government Association; Public Health England; Association of Directors of Public Health. Sexual health commissioning frequently asked questions. 2013. http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/3880628/PUBLICATION Accessed on: 14/04/2014.
3. The Local Authorities (Public Health Functions and Access to Premises by Local Healthwatch Representatives) Regulations 2013. <http://www.legislation.gov.uk/uksi/2013/351/part/1/made> Accessed on: 14/04/2014. (*Note - the regulation sets out Local Authorities responsibilities to provide open access sexual health services including contraceptive services*).
4. Department of Health. Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities. 2013. <https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities> Accessed on: 14/04/2014.
5. Department of Health. Public Health Services Contract 2014 to 2015. 2014. <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published> Accessed on: 14/04/2014.
6. Department of Health. Public Health Services Contract 2014/15: Guidance on non-mandatory contract for public health services. 2014. <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published> Accessed on: 14/04/2014
7. Department of Health. Sexual Health Services: Key Principles for Cross Charging. 2013. <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published> Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

8. Department of Health. Sexual Health Clinical Governance: Key principles to assist service commissioners and providers to operate clinical governance systems in sexual health services. 2013.
<https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published> Accessed on: 14/04/2014.
9. Public Health England. HIV, sexual and reproductive health: current issues bulletin. 2013-14. <https://www.gov.uk/government/collections/hiv-sexual-and-reproductive-health-current-issues-bulletin> Accessed on: 14/04/2014.

Service specifications

10. Department of Health. Integrated Sexual Health Services: National Service Specification - A Suggested Service Specification for Integrated Sexual Health Services. 2013. <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published> Accessed on: 14/04/2014.
11. NHS England. Service specifications for Specialised Human Immunodeficiency Virus (HIV) Services (Adult) and Specialised Human Immunodeficiency Services (Children). 2013.
<http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-b/b06/> Accessed on: 14/04/2014.
12. NHS England. Service Specification No 15 NHS Infectious Diseases in Pregnancy Screening Programme. 2013.
<https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015> Accessed on: 14/04/2014.
13. NHS England. Service Specification No 25 Cervical Screening. 2013
<https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015> Accessed on: 14/04/2014.
14. NHS England. Service Specification No 30 Sexual Assault Services. 2013.
<https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015> Accessed on: 14/04/2014.
15. NHS England. Securing Excellence in commissioning Sexual Assault Services for people who experience violence. 2013.
<http://www.england.nhs.uk/2013/06/13/commis-sex-assault-serv/> Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

NICE guidance

- 16.1 National Institute for Health and Care Excellence. Contraceptive services with a focus on young people up to the age of 25. NICE public health guidance 51. 2014. <http://publications.nice.org.uk/contraceptive-services-with-a-focus-on-young-people-up-to-the-age-of-25-ph51> Accessed on: 14/04/2014.
- 16.2 National Institute for Health and Care Excellence. Contraceptive services. NICE local government briefing 17. 2014. <http://www.nice.org.uk/localgovernment/PublicHealthBriefingsForLocalGovernment.jsp> Accessed on: 14/04/2014.
- 16.3 National Institute for Health and Care Excellence. Long-acting reversible contraception NICE clinical guideline 30. 2005, updated 2013. <http://publications.nice.org.uk/long-acting-reversible-contraception-cg30> Accessed on: 14/04/2014.
- 16.4 National Institute for Health and Care Excellence. Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. NICE public health guidance 43. 2012. <http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43> Accessed on: 14/04/2014.
- 16.5 National Institute for Health and Care Excellence. Increasing the uptake of HIV testing among men who have sex with men. NICE public health guidance 34. 2011. <http://publications.nice.org.uk/increasing-the-uptake-of-hiv-testing-among-men-who-have-sex-with-men-ph34> Accessed on: 14/04/2014.
- 16.6 National Institute for Health and Care Excellence. Increasing the uptake of HIV testing among black Africans in England. NICE public health guidance 33. 2011. <http://publications.nice.org.uk/increasing-the-uptake-of-hiv-testing-among-black-africans-in-england-ph33> Accessed on: 14/04/2014.
- 16.7 National Institute for Health and Care Excellence. One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. NICE public health intervention guidance 3. 2007. <http://publications.nice.org.uk/prevention-of-sexually-transmitted-infections-and-under-18-conceptions-ph3> Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

Local government and health and wellbeing boards

17. Department of Health. Directors of Public Health in Local Government: Roles, Responsibilities and Context. 2013.
<https://www.gov.uk/government/publications/role-of-the-director-of-public-health-in-local-authorities> Accessed on: 14/04/2014.
17. Local Government Association. Local Public Service Transformation: A Guide to Whole Place Community Budgets. 2013. http://www.local.gov.uk/community-budgets/-/journal_content/56/10180/3930626/ARTICLE Accessed on: 14/04/2014.
19. Department of Health. Statutory Guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies. 2013.
<https://www.gov.uk/government/consultations/health-and-wellbeing-board-duties> Accessed on: 14/04/2014.
20. Department of Health. A short guide to health and wellbeing boards. 2012.
<http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/hwb-guide/> Accessed on: 14/04/2014.
21. Local Government Association. Health and wellbeing system bulletins. 2013-2014. http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4051538/ARTICLE Accessed on: 14/04/2014.
22. Association of Directors of Children's Services; Department of Health; Local Government Group; NHS Alliance; NHS Confederation; Royal College of General Practitioners; Royal Society for Public Health; Solace. Operating principles for health and wellbeing boards. 2012.
http://www.local.gov.uk/c/document_library/get_file?uuid=1ccc06cb-d44b-43c6-b04c-f7b713e03122&groupId=10180 Accessed on: 14/04/2014.
23. Local Government Association. Tackling teenage pregnancy: local government's new public health role. 2013.
http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/3964823/PUBLICATION Accessed on: 14/04/2014.
24. Local Government Association. Community Pharmacy - local government's new public health role. 2013. http://www.local.gov.uk/publications/-/journal_content/56/10180/5597846/PUBLICATION Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

25. Department of Health; Local Government Association; NHS Confederation; NHS Institute for Innovation and Improvement. Working with local government: a guide for GP commissioners. 2012. <http://www.nhsconfed.org/Publications/Documents/government-guide-commissioners.pdf> Accessed on: 14/04/2014.
26. Department of Health; Local Government Association; NHS Confederation; NHS Institute for Innovation and Improvement. Working with GP commissioners: a guide for local councillors and officers. 2012. <http://www.nhsconfed.org/Publications/Documents/gp-commissioners-councillors-officers.pdf> Accessed on: 14/04/2014.
27. Local Government Association. A quick guide to local government for health commissioners and providers. 2012. http://www.local.gov.uk/health/-/journal_content/56/10180/3697173/ARTICLE Accessed on: 14/04/2014.
28. Local Government Association. Commissioning for better public services. 2012. http://www.local.gov.uk/c/document_library/get_file?uuid=3e20c466-923c-4eb6-997b-1f493b7b7d4c&groupId=10180 Accessed on: 14/04/2014.
29. Local Government Association. Public health transformation nine months on: bedding in and reaching out. 2014. http://www.local.gov.uk/publications/-/journal_content/56/10180/5897964/PUBLICATION Accessed on: 14/04/2014.

Health outcomes

30. Department of Health. Public Health Outcomes Framework 2013 to 2106. 2013 <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency> Accessed on: 14/04/2014.
31. Department of Health. Public Health Outcomes Framework data tool. 2013. <http://www.phoutcomes.info> Accessed on: 14/04/2014.
32. Department of Health. NHS Outcomes Framework 2014 to 2015. 2013. <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015> Accessed on: 14/04/2014.
33. Department of Health. Adult Social Care Outcomes Framework 2014 to 2015. 2013. <https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015> Accessed 14/04/2014.
34. Public Health England. Sexual and Reproductive Health Profiles. <http://fingertips.phe.org.uk/profile/sexualhealth> Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

National standards and clinical guidance

35. British Association for Sexual Health and HIV; MEDFASH. Standards for the Management of Sexually Transmitted Infections. 2014.
<http://www.medfash.org.uk/standards-for-the-management-of-stis> Accessed on: 14/04/2014.
36. Faculty for Sexual & Reproductive Healthcare. Quality Standard for Contraceptive Services. 2014.
<http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf>
Accessed on: 14/04/2014.
37. Faculty for Sexual & Reproductive Healthcare. Service Standards for Sexual and Reproductive Healthcare. 2013.
http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf Accessed on: 14/04/2014.
38. British HIV Association. Standards of Care for People Living with HIV. 2013.
<http://www.bhiva.org/standards-of-care-2013.aspx> Accessed on: 14/04/2014.
39. Royal College of General Practitioners; British Association for Sexual Health and HIV. Sexually Transmitted Infections in Primary Care. 2013.
http://www.bashh.org/BASHH/BASHH_Groups/BASHH_Primary_Care_Group/BASHH/BASHH_Groups/BASHH_Primary_Care_Group.aspx?hkey=1e5feacc-198d-4516-8277-3dc51ade47e8 Accessed on: 14/04/2014.
40. Faculty for Sexual & Reproductive Healthcare. Clinical Guidance – Emergency Contraception. 2012.
<http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf>
Accessed on: 14/04/2014.
41. British Association for Sexual Health and HIV; British HIV Association. UK National Guideline on Safer Sex Advice. 2012. <http://www.bhiva.org/safersex.aspx> Accessed on: 14/04/2014.
42. British Association for Sexual Health and HIV. Statement on Partner Notification for Sexually Transmissible Infections. 2012.
<http://www.bashh.org/documents/2012%20Partner%20Notification%20Statement.pdf> Accessed on: 14/04/2014.
43. British HIV Association; British Psychological Society; MEDFASH. Standards for psychological support for adults living with HIV. 2011.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

<http://www.bhiva.org/StandardsForPsychologicalSupport.aspx> Accessed on: 14/04/2014.

44. British Association for Sexual Health and HIV. UK Guideline for the use of post-exposure prophylaxis for HIV following sexual exposure. 2011. <http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx>. Accessed on: /2014.
45. Royal College of Obstetricians & Gynaecologists. The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7. 2011. <http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion> Accessed on: 14/04/2014.
46. UK National Guidelines for HIV Testing (BHIVA 2008) <http://www.bhiva.org/hivtesting2008.aspx> Accessed on: 14/04/2014.
47. MEDFASH. Progress and priorities - working together for high quality sexual health. 2008. <http://www.medfash.org.uk/publications> Accessed on: 14/04/2014.
48. MEDFASH. Recommended Standards for Sexual Health Services. 2005. <http://www.medfash.org.uk/publications> Accessed on: 14/04/2014.
49. Royal College of Obstetricians & Gynaecologists. Male and Female Sterilisation, Evidence-based Clinical Guideline Number 4. 2004. <http://www.rcog.org.uk/womens-health/clinical-guidance/male-and-female-sterilisation>. Accessed on: 14/04/2014.
50. Health Protection Agency, National Chlamydia Screening Programme Standards (6th Edition 2012) <http://www.chlamydia-screening.nhs.uk/ps/standards.asp> Accessed on: 14/04/2014.

The above list includes key standards and guidance. Additional clinical guidance on a range of related topics is available on the FSRH, BASHH and BHIVA websites.

Commissioning documents

51. NHS England. Towards commissioning excellence: developing a strategy for commissioning support units. 2013. <http://www.england.nhs.uk/2013/06/13/fut-of-comm-supp-serv/> Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

52. Department of Health. You're welcome: Quality criteria for young people friendly health services. 2011.
<https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services> Accessed on: 14/04/2014.
53. NHS England. Securing Excellence in commissioning primary care. 2012.
<http://www.england.nhs.uk/2012/06/22/ssom-comm-pc/> Accessed on: 14/04/2014.
54. NHS Commissioning Board. The NHS Standard Contract - A guide for clinical commissioners. 2013.
<http://www.england.nhs.uk/wp-content/uploads/2013/02/contract-guide-clinical.pdf>. Accessed on 14/04/2014
55. Local Government Association. Commissioning and procurement. 2014.
<http://www.local.gov.uk/commissioningandprocurement> Accessed on: 14/04/2014.
56. National Audit Office. Successful Commissioning Guide: How to secure value for money through better financial relationships with third sector organisations. 2014. <http://www.nao.org.uk/successful-commissioning/> Accessed on: 14/04/2014.
57. Department of Health. HIV Outpatient pathway updated guidance. 2013.
<https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance> Accessed on: 14/04/2014.

Other helpful documents

58. The Lesbian & Gay Foundation. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. 2013.
<http://www.lgf.org.uk/policy-research/the-lgbt-public-health-outcomes-framework-companion-document/> Accessed on: 14/04/2014.
59. National AIDS Trust. Clinical senates Fact Sheet. 2014.
<http://www.nat.org.uk/Information-and-Resources/New%20publications.aspx#healthandsocialcare> Accessed on: 14/04/2014.
60. National AIDS Trust. Commissioning HIV Testing Services in England (Second Edition). 2013
<http://www.nat.org.uk/Information-and-Resources/New%20publications.aspx#preventionandtesting>. Accessed on: 14/04/2014.

PLEASE NOTE: THIS IS A DRAFT. THE CONTENT WILL BE REVISED FOR THE FINAL PUBLICATION. PHE BRANDING WILL ALSO APPLIED FOR PUBLICATION.

61. National AIDS Trust. Appendices to NAT's Practical Guide for Commissioners Commissioning HIV Testing Services in England. 2013. <http://www.nat.org.uk/Information-and-Resources/New%20publications.aspx#preventionandtesting> Accessed on: 14/04/2014.
62. Brook; FPA. Unprotected Nation. The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. A Report by Development Economics. 2013. <http://www.fpa.org.uk/news/unprotected-nation-cuts-sexual-health-services-cost-uk-%C2%A3136-billion> Accessed on: 14/04/2014.
63. Advisory Group on Contraception. Commissioning high quality contraceptive services – Recommendations to NHS England. 2014. http://theagc.org.uk/?page_id=6 Accessed on: 14/04/2014.
64. Advisory Group on Contraception. Commissioning high quality contraceptive services – A guide for local authority commissioners. 2014. http://theagc.org.uk/?page_id=6 Accessed on: 14/04/2014.
65. Advisory Group on Contraception. Commissioning high quality contraceptive services – A guide for clinical commissioning groups. 2014. http://theagc.org.uk/?page_id=6 Accessed on: 14/04/2014.

Annex 2. Facilitating whole system commissioning: overview of relevant legislation

A2.1. The legislation facilitating a whole system commissioning approach is the NHS Act 2006²⁵ and the Health and Social Care Act 2012²⁶. The key sections of the Acts “promoting integration” and “encouraging integrated working” are highlighted below. Both are enshrined as duties in the Health and Social Care Act 2012. The Act further imposes a duty on NHS bodies and local authorities to co-operate with one another in exercising their respective functions. The Department of Health underlines the duty to co-operate in its circular to local authorities on the ring-fenced public health grant (LAC(DH)(2013)1 10 January 2013) thus:

A2.2. “The Health and Social Care Act 2012 will promote the principle of integrated working by stating that in exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must cooperate with one another in order to secure and advance the health and welfare of the people of England and Wales. This confers a duty of co-operation between Directors of Public Health, clinical commissioning groups (CCGs) and the wider NHS when carrying out their respective functions²⁷”.

Duty to promote integration

A2.3. Section 13N of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, outlines the “Duty as to promoting integration” for the NHS Commissioning Board (now NHS England). Section 13N(1) provides that:

- (1) The Board must exercise its function with a view to securing that health services are provided in an integrated way where it considers that this would:
 - (a) improve the quality of those services (including the outcomes that are achieved from their provision)
 - (b) reduce inequalities between persons with respect to their ability to access those services
 - (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

²⁵ <http://www.legislation.gov.uk/ukpga/2006/41/contents>

²⁶ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

²⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213323/LA-Grant-cir-and-allocations1.pdf

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A2.4. Section 14Z1 of the 2006 Act, as amended, outlines the “Duty as to promoting integration” for Clinical Commissioning Groups. The terms of the duty are identical to those outlined above for NHS England

Duty to encourage integrated working

Joint Health and Wellbeing Strategies

A2.5. Section 193 of the Health and Social Care Act amended the Local Government and Public Involvement in Health Act 2007, to introduce duties on local authorities, CCGs and NHS England (See new sections 116A and 116B of the Local Government and Public Involvement in Health Act)

A2.6. Firstly, where a joint strategic needs assessment is prepared, the responsible local authority and its partner CCGs must prepare a joint health and wellbeing strategy for meeting the needs included in the assessment. The functions of preparing a joint strategic needs assessment and preparing a health and wellbeing strategy are to be exercised by the Health and Wellbeing Board established by the local authority. They must in particular consider how far those needs could be more effectively met under section 75 arrangements (see further below).

A2.7. Other subsections require the local authority and its partner CCGs to involve the Local Healthwatch organisation and local people in the preparation of the strategy, and to publish strategies prepared under the section.

A2.8. Secondly, responsible local authorities and their partner CCGs, must, in exercising their functions, have regard to any joint strategic needs assessment or any joint health and wellbeing strategy prepared by the responsible local authority and its partner CCGs which is relevant to the exercise of the functions.

A2.9. Similarly NHS England must have regard to any such relevant assessments and strategies when exercising functions in arranging for the provision of health services in relation to the area of a responsible local authority.

A2.10. Section 195 of the Health and Social Care Act 2012 imposes a duty on Health and Wellbeing Boards to encourage integrated working.

Section 75 of the NHS Act 2006

A2.11. Section 75 of the NHS Act 2006 governs arrangements between NHS bodies and local authorities. Section 75 of the NHS Act 2006 sets out a regulation-making power to prescribe arrangements which may be entered into, functions to which those arrangements may relate, and the NHS bodies and local

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authorities which may enter into them. The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617) are deemed to be made under section 75. They list local authority public health functions under the NHS Act 2006 and CCG commissioning functions under that Act as functions which may be the subject of partnership arrangements where the arrangements are likely to lead to an improvement in the way those functions are carried out.

A2.12. Further details are outlined in Annex B of Sexual Health Clinical Governance: Key principles to assist service commissioners and providers to operate clinical governance systems in sexual health services (Department of Health 2013) – see Annex 1. A partnership arrangement between a local authority and a CCG under section 75 is one option to fulfil the duty for integrated working. Subject to the statutory requirements in the 2000 Regulations mentioned above, this can include the two bodies contributing to a fund (a “pooled budget”) to commission services collaboratively. NHS England’s Area Teams can also participate in collaborative commissioning subject to authorisation of the section 75 arrangement by the relevant Regional office²⁸. An example of how Luton Borough Council and Luton CCG have used this mechanism to provide integrated services for children with additional needs is given below. Further options exist to facilitate collaboration between local authorities, CCGs and NHS England. These include collaboration without pooled budgets and jointly agreed service specifications and are outlined in sections 4 and 5 of the Framework

Commissioning integrated services for children and young people through a section 75 agreement

A2.13. Luton Borough Council and Luton CCG have a formal partnership agreement within Section 75 of the National Health Service Act 2006. The agreement was established between the Council and NHS Luton in 2011 for the integrated management of specified services for children and young people with additional needs. The Council takes lead responsibility. Under the agreement the CCG formally delegates its Health Related Functions, as identified in the agreement, to the Council.

A2.14. A joint management team oversees both the service and the partnership arrangements. The partners both contribute revenue to the service, within agreed budget planning and financial management processes. These include

²⁸https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284259/HIV_Sexual_and_Reproductive_Health_bulletin_issue_3_FINAL.pdf

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the timetable and deadlines for financial planning, regular financial management reports and mechanisms for dealing with over- or underspends. The agreement has clauses covering review, termination, variation, dispute and resolution, complaints, statutory obligations and governing law.

A2.15. The agreement's schedules cover the following:

A2.16. **Aims and objectives** to maximise the efficiency of services through the flexibilities afforded by a Section 75 agreement and to improve quality and outcomes for clients. The aims of partnership working and a single integrated joint commissioning process are outlined.

A2.17. **Financial arrangements** including finance flows, financial planning and budget setting process, budget performance and access to financial information.

A2.18. **Governance and performance reporting** through a joint management group chaired by a senior officer of the Council. The group has responsibility for the annual commissioning and financial plan, risk management, outcomes, systems for client feedback and a report to both executives. Performance reporting uses national and local indicators, updates on service development plans and reports on action plans arising from service and regulatory inspection.

A2.19. Services in the agreement, including strategic objectives, legislative context and a description of the joint commissioning team and integrated children's and young people's services. The aim of the integrated service is to provide a coordinated and accessible service with a single point of referral, information, assessment and delivery of support for disabled children and their families. The objective of the service is that children and young people with disabilities and/or a life limiting condition will be able to easily access the support of their choice from a flexible, responsive and coherent network of high quality services, allowing them and their families to lead lives that are as normal as possible.

A2.20. Key operational structures and processes are designed to support the delivery of joined up, child focused services. These include:

- a joint management structure
- clear service standards, protocols and eligibility criteria
- a joined-up assessment process
- an embedded Lead Professional approach
- joint planning and decision-making for care packages agreed at a Joint Allocation Panel which may be joint funded across health and social care

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- shared data and information sharing protocols

Contact: David Bruce, Head of Integrated Commissioning Team, Children and Families, Luton Borough Council david.bruce@luton.gov.uk

Annex 3. Policy and guidance for local authorities, CCGs and NHS England

A3.1. Published documents supporting local authorities, CCGs, and NHS England with their SRH and HIV commissioning are listed in Annex 1 with full references. A summary of key supporting policy and guidance is given below.

Framework for Sexual Health Improvement in England

A3.2. A Framework for Sexual Health Improvement in England (DH, 2013), provides a guide for those responsible for planning and commissioning sexual health services, and for those who provide them.

A3.3. The framework suggests five objectives for local service delivery to ensure good outcomes are maintained and improved:

- accurate, high-quality and timely information that helps people to make informed decisions about their relationships, sex and sexual health
- preventative interventions that build personal resilience and self-esteem and promote healthy choices
- rapid access to confidential, open access integrated sexual health services in a range of settings, accessible at convenient times
- early, accurate and effective diagnosis and treatment of STIs including HIV, combined with the notification of partners who may be at risk
- joined up provision that enables seamless patient journeys across a range of sexual health and other services - this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings.

Commissioning sexual health services and interventions: best practice for local authorities

A3.4. This guidance is designed to help local authorities commission high quality sexual health services for their local area as part of their wider public health responsibilities, with costs met from their ring-fenced public health grant. It provides:

- guidance on the legal requirements to provide comprehensive, open access sexual health services for contraception and testing and treatment of sexually transmitted infections
- best practice, and references to a number of other resources which local authorities may find useful.

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A3.5. Local authorities are required by legislation to arrange for the provision of confidential, open access STI testing and treatment and contraception services. This legislation means that anyone who is in an area, whether resident or not, is entitled to use the services provided in that area free of charge and services cannot be restricted only to people who can prove they live in the area or who are registered to, or referred by, a local GP or on the basis of age.

The NHS Outcomes Framework

A3.6. The NHS Outcomes Framework was developed in 2010 following public consultation. It is updated annually. It sits, alongside the Adult Social Care and Public Health outcomes frameworks, at the heart of the health and care system. The framework:

- provides a national overview of how well the NHS is performing
- is the primary accountability mechanism, in conjunction with the Mandate, between the Secretary of State for Health and NHS England
- drives up quality throughout the NHS by encouraging a change in culture and behaviour focused

A3.7. Indicators in the NHS Outcomes Framework 2014/15 are grouped around five domains focusing on improving health and reducing inequalities by:

- preventing people from dying prematurely;
- enhancing quality of life for people with long term conditions;
- helping people to recover from episodes of ill health or following injury;
- ensuring that people have a positive experience of care;
- treating and care for people in a safe environment and protecting them from avoidable harm.

The Public Health Outcomes Framework

A3.8. The Public Health Outcomes Framework (PHOF) for 2013–16 includes three sexual health indicators. They are as follows:

- Under 18 conceptions;
- People presenting with HIV at a late stage of infection
- Chlamydia diagnoses (15–24 year olds)

A3.9. A number of other indicators in the PHOF are also relevant for sexual and reproductive health and HIV e. g. violent crime including sexual violence; take up of the NHS health check programme; low birth weight of term babies.

Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

A3.10. This provides details of the requirements each local authority needs to have in place for the provision of open access sexual health services, including

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contraceptive services, for the benefit of all people present in its area specifically:

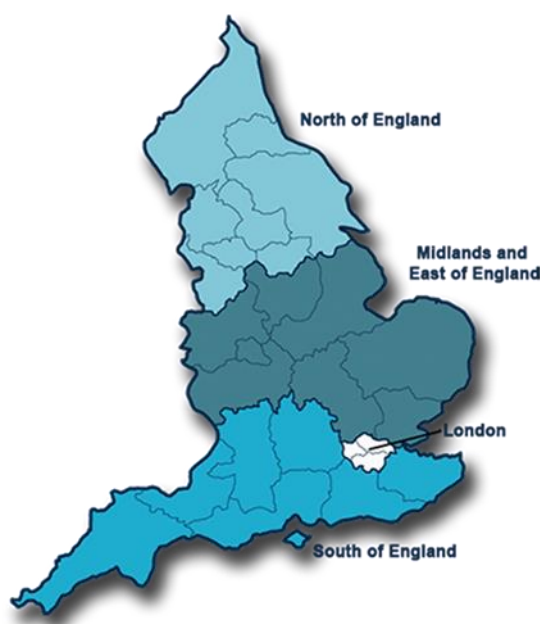
- preventing the spread of sexually transmitted infections
- treating, testing and caring for people with such infections
- notifying sexual partners of people with such infections
- advice on and reasonable access to a broad range of contraceptive substances and appliances

A3.11. It does not set out how the services should be provided, nor does it impose any requirements on the numbers of services, locations, opening times, type of service model, waiting times or staffing levels. This will be determined locally and will make a difference to the quality of services and the achievement against the Public Health Outcomes Framework (PHOF) and the objectives of the *Framework for sexual health improvement in England*.

Annex 4. Overview of NHS England structures and responsibilities for sexual and reproductive health and HIV commissioning

Regional and area team structure and roles

A4.1. NHS England has four regions, North, Midlands and East, South and London, with 27 associated Area Teams (ATs).



A4.2. All 27 ATs have the same core functions:

- CCG development and assurance
- emergency planning, resilience and response
- quality and safety
- partnerships
- configuration
- system oversight

SRH and HIV commissioning responsibilities

Direct commissioning for five areas of health care is by area teams supported by the Operations Directorate's Health and Justice, Armed Forces and Public Health teams. Four of these areas of healthcare are relevant to SRH and HIV and are highlighted in red:

- Immunisation and screening (including HPV, cervical screening, infectious diseases in pregnancy screening)

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- SARCs
- Health and justice
- Healthcare for armed forces and their families
- Universal health of 0-5 year olds

All ATs are involved in commissioning immunisation and screening programmes. All ATs have responsibility for commissioning primary care including general practice.

Ten ATs are hubs for specialised services commissioning (highlighted in green) including HIV treatment and care for adults and children and specialist foetal medicine services.

Ten ATs lead on health and justice (highlighted in blue) including sexual health and HIV elements of prison health services. Justice health teams also lead on SARCs.

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NHS England area teams – specialised services and justice and health hubs

NHS England North of England (nine ATs)	NHS England Midlands and East (eight LTs)
West Yorkshire	Arden, Herefordshire and Worcestershire area team
South Yorkshire and Bassetlaw	Birmingham, Solihull and the Black Country
North Yorkshire and Humber	Derbyshire and Nottinghamshire
Merseyside	(and health and justice)
Greater Manchester	Essex
Lancashire	Hertfordshire and the South Midlands
Durham, Darlington and Tees	Leicestershire and Lincolnshire
Cumbria, Northumberland, Tyne and Wear	Shropshire and Staffordshire area team
Cheshire, Warrington and Wirral	
NHS England South (seven ATs)	NHS England London (three ATs)
Bath, Gloucestershire, Swindon and Wiltshire	North East London (and health and justice)
Bristol, North Somerset, Somerset and South Gloucestershire (and health and justice)	North West London (and health and justice)
Devon, Cornwall and Isles of Scilly	South London (and health and justice)
Kent and Medway	
Surrey and Sussex	
Wessex	

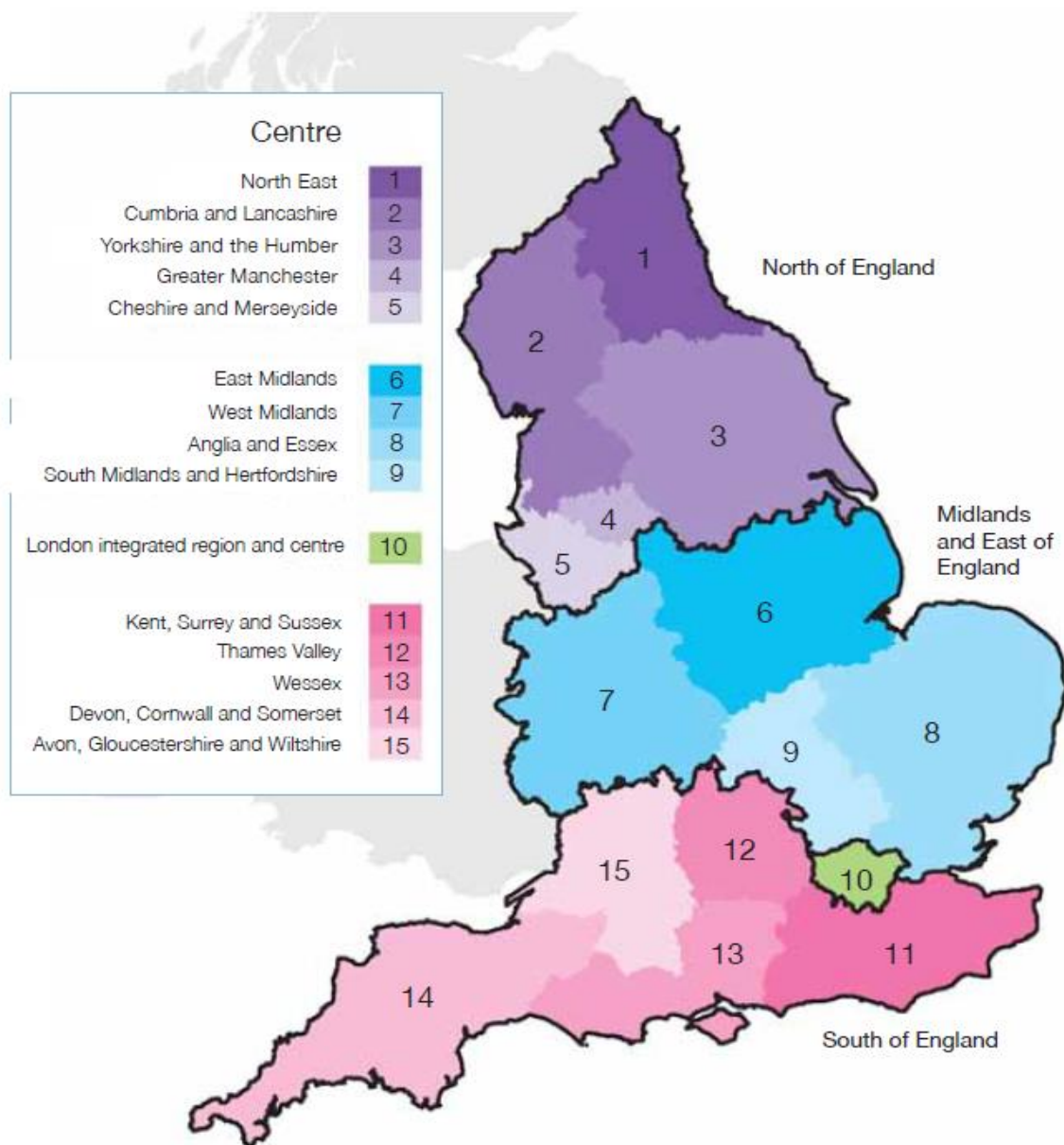
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NHS England – internal SRH and HIV interfaces

Primary Care	Health in justice	Infectious diseases in pregnancy screening programme	Treatment and care for PLWH
<p>Contraceptive services provided as an 'additional service' under the GP contract (GMS, PMS or APMS) (ATs)</p> <p>National cervical screening programme in general practice settings (NHS England directly commissioned services public health team)</p>	<p>HIV treatment in prisons (NHS England - Health in Justice team/ATs)</p> <p>Sexual health needs of prisoners (NHS England Health in Justice team/ATs)</p> <p>HIV treatment and care of prisoners on release or licence (NHS England Specialised Services/AT hub)</p> <p>Note - Sexual and reproductive health needs of prisoners on release or licence (LAs)</p>	<p>NHS infectious diseases in pregnancy screening programme including antenatal screening for HIV, syphilis, Hepatitis B (NHS England directly commissioned services team/ATs)</p> <p>Treatment and care for pregnant women diagnosed as HIV positive (NHS England, specialised services/AT hubs)</p> <p>Treatment and care of pregnant women with syphilis (LAs)</p>	<p>Treatment and care services for PLWH and all antiretroviral prescribing (NHS England specialised services/AT hubs)</p> <p>Primary care for PLWH including all non-specialist prescribing (NHS England primary care commissioning directorate/ATs)</p>

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Annex 5. Public Health England: regions and centres



Annex 6. Managing outbreaks of Sexually Transmitted Infections

Managing outbreaks of Sexually Transmitted Infections: a Lymphogranuloma venereum (LGV) outbreak in urban centres: lessons for commissioners

A6.1. The past ten years have seen a steady rise in new diagnoses of sexually transmitted infections (STIs). While much of this is due to improved STI testing, increased transmission in certain population groups has also occurred. Outbreaks of STIs (including syphilis, gonorrhoea and LGV) have been an important feature of STI epidemiology during this period requiring a prompt integrated public health response by PHE, local government, CCGs and NHS England. The management of a sustained outbreak of LGV among men who have sex with men (MSM) predominantly in London, Brighton and Manchester is one example. LGV is an STI caused by certain types of *Chlamydia trachomatis* which has emerged as an important public health problem in predominantly HIV-positive MSM in western industrialised countries over the last decade. Between 2003 and mid-2012 over 2000 cases of LGV were diagnosed in the UK.

A6.2. Outbreak and incident management is a key public health measure and a core element of commissioning of sexual health services. The aim of the LGV investigation, as with the management of other STI outbreaks, was to prevent local transmission through increased diagnosis, treatment and management, and increased awareness among risk groups.

A6.3. PHE has produced comprehensive guidance for the management of STI outbreaks. When an outbreak is identified, a local OCT, led by a Consultant in Communicable Disease Control, is formed with appropriate representation depending on patterns of local transmission and likely public health impact. In the case of the LGV outbreak, PHE and BASHH developed infection control guidelines focusing on offering LGV testing to MSM. Since there was a high level of co-infection with HIV, testing was offered during routine clinic appointments together with raising awareness among those at risk. Chlamydia positive men with symptoms were also tested for LGV.

A6.4. If there is evidence the outbreak is spreading beyond local and regional boundaries, a national OCT is established to enable a standardised and coordinated response. This happened for the LGV outbreak. Control measures included expanded testing, treatment and partner notification, as well as strategies for raising

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awareness in the local populations and among health professionals. The promotion of safer sex through the use of condoms, leaflet campaigns and targeted press releases, was also employed in collaboration with Terrence Higgins Trust.

Results

A6.5. Improving sexual health, and controlling STI outbreaks, requires strong local sexual health networks including all providers and commissioners. Service providers have a responsibility to report concerns about increased STI cases promptly to the local PHE centre and commissioners to ensure swift public health action. Outbreaks are more likely to be contained if identified and acted upon early.

A6.6. Local government, CCGs and NHS England may also need to commission additional services to support outbreak management. In urban centres, this might include targeted prevention work with MSM and other population groups at risk such as young heterosexuals including using internet or social media resources. Commissioners should also build learning from outbreaks into future commissioning plans. Collating and reporting information from investigations can inform the development of intervention strategies and standards for managing future outbreaks. BASHH standards for testing and treatment of HIV positive MSMs were updated in response to the LGV outbreak described.

Contact details

Gwenda Hughes, PHE

Email: gwenda.hughes@phe.gov.uk

Ian Simms, PHE

Email: ian.simms@phe.gov.uk

Annex 7. Glossary

APMS	Alternative Provider Medical Services
ARV	Antiretroviral
AT	Area team
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
BPAS	British Pregnancy Advisory Service
CCG	Clinical commissioning group
CLAHRC	Collaborations for Leadership in Applied Health Research and Care
CRG	Clinical Reference Group
DH	Department of Health
DPH	Director of Public Health
EHC	Emergency hormonal contraception
ESHHCG	The English Sexual Health and HIV Commissioners Group
FSRH	Faculty of Sexual and Reproductive Healthcare
GMS	General Medical Services
GUM	Genitourinary medicine
HEE	Health Education England
HIV	Human immunodeficiency virus
HWB	Health and wellbeing board
IUD	Intrauterine device
IUS	Intrauterine system
JHWS	Joint health and wellbeing strategy
JSNA	Joint strategic needs assessment
LA	Local authority
LARC	Long acting reversible contraception
LES	Locally enhanced service
LETB	Local education and training board
LSOA	Lower super output area
NAT	National AIDS Trust
NCSP	National Chlamydia Screening Programme
NIHR	National Institute of Health Research
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
PEPSE	Post-exposure prophylaxis following sexual exposure
PGD	Patient group direction
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PLWH	People living with HIV

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PMS	Personal Medical Services
PN	Partner notification
PSHE	Personal, social, health and economic (education)
QALY	Quality adjusted life year
SARC	Sexual Assault Referral Centre
SHLC	Sexual Health Lead Commissioner
SRE	Sex and Relationships Education
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TasP	Treatment as Prevention
TUPE	Transfer of Undertakings (Protection of Employment)

Annex 8. Acknowledgements