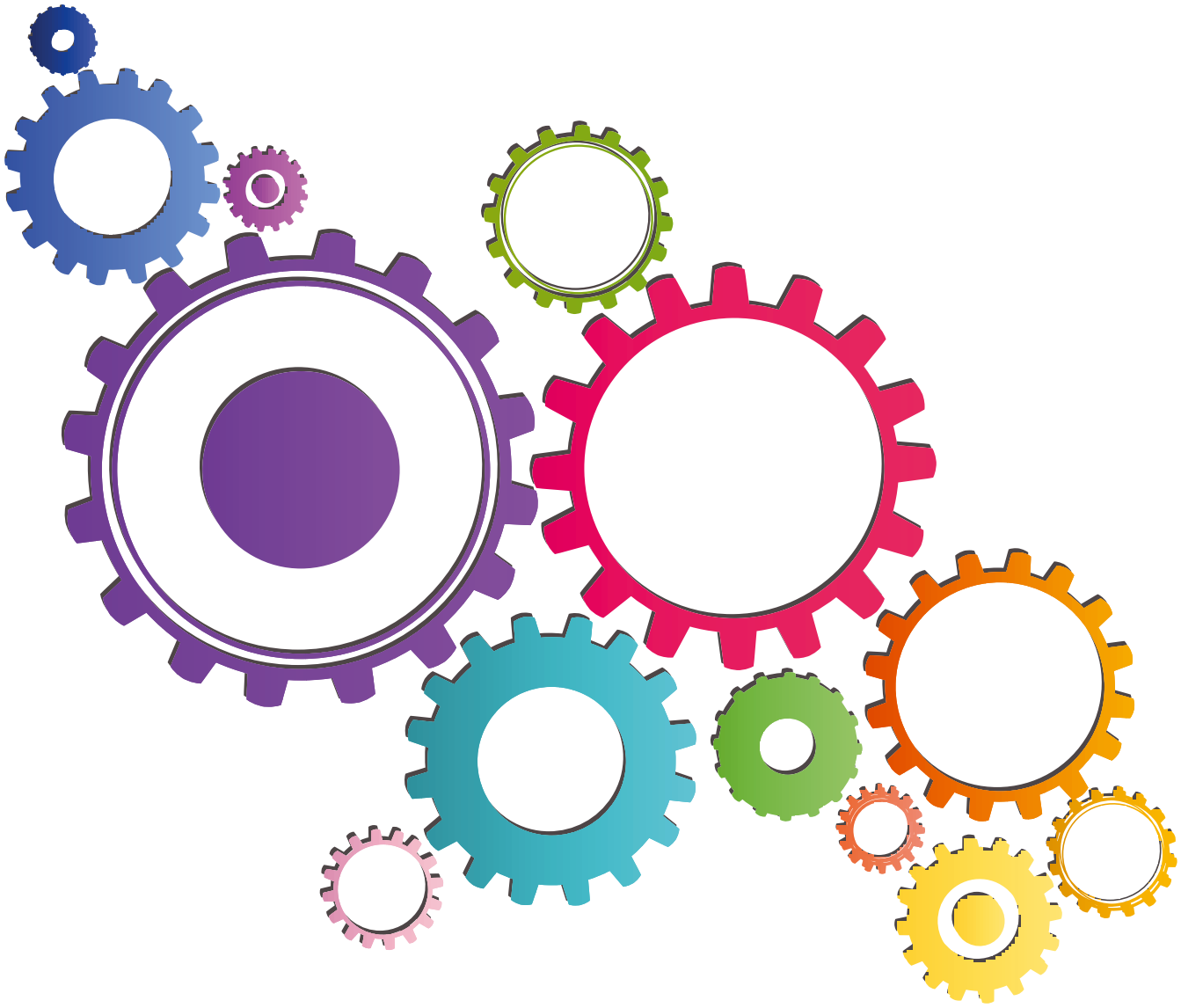
Public Health England

Making it work

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

Part 2: Case studies



September 2014

Department of Health

Local Government Association

Association of Directors of Public Health

NHS England

Case Studies

These case studies demonstrate models of existing and emerging local practice to illustrate how commissioners are working collaboratively to meet the needs of their local populations and address health inequalities.

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 primary care trust (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 necessarily 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 – but to operate 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

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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 three million, including ten local councils, 12 clinical commissioning groups and eight 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 six weeks. Commissioners from the ten 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 ten 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. These include the Greater Manchester chlamydia screening programme, a central booking service for abortions, multilateral abortion contracts, sperm washing guidelines for people living with HIV, locally commissioned services for pharmacy provision including a service specification and training, condom distribution, and specifications for integrated sexual health and young people's sexual health services. 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.

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.

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

Health in Hackney Scrutiny Commission undertook a scrutiny review focusing on the aim of "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 sexual health-related priorities which the council is obliged to address in the Public Health Outcomes Framework.

Diagnosed HIV prevalence in the UK is 2 per 1,000 of the population aged 15-59 years. In Hackney it is 7.4 per 1,000, 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 Street 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.

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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, 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

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

Each local authority has its own Public Health Consultant with its own team of programme managers and officers. The director of public health is jointly appointed across the six local authorities, sits on each council's health and wellbeing board and is overseen by an advisory board comprising directors/CEOs from the six local authorities. She leads a shared team which includes the project management for the re-procurement of sexual health services.

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 funding, concentrating expertise and developing a county-wide approach. It also facilitates liaison with the commissioners of HIV treatment and care and abortion services. Berkshire has two main sexual health service providers: one hospital-based 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 integrated sexual health service 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 for an external reviewer.

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 to the lead commissioner. 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.

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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 and 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 & local authority commissioning units, where these exist, and the local commissioning support unit. Commissioners hold a joint pre-meeting prior to quarterly service review meetings.

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.

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

An Integrated Commissioning Team for Child Health in Wigan 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 and 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 service user.

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.

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 who has 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 rates and uptake of LARC .

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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 plan collaboratively to commission GUM services.

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

In the first year, lessons have been learned by commissioners and providers and these may inform the approach to any future open procurement. 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.

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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 that 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. Area teams (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 AT (specialised commissioning hub) and ensure they had made contact with the leads for sexual health commissioning in the relevant local authorities
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 to 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.

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

Leicester City Council and Leicestershire and Rutland Councils re-commissioned sexual 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 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. A steering group reported to the programme board. The local authority representatives on this group 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 Support 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 issues.

Results

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

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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. It 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. It 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.

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 believes 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.

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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 healthcare 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 breastfeeding and alcohol consumption
- the targeted adolescence team and Sure Start Children's Centres providing brief health promotion interventions on risk-taking behaviours including drugs and alcohol, 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

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.

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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 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 contract or provider-commissioner meeting, but rather a forum for partners to share updates on their activities acting 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 the establishment of a formal consultation group of 30 young people, 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.

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.

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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 Areas [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, 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 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.

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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 commissioner role, highlights good practice, enhances national consistency and helps maintain the profile of sexual health and HIV. Its work supports the development of collaborative commissioning to promote high quality and cost-effective local decision-making.

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 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 the Department of Health.

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September 2014