

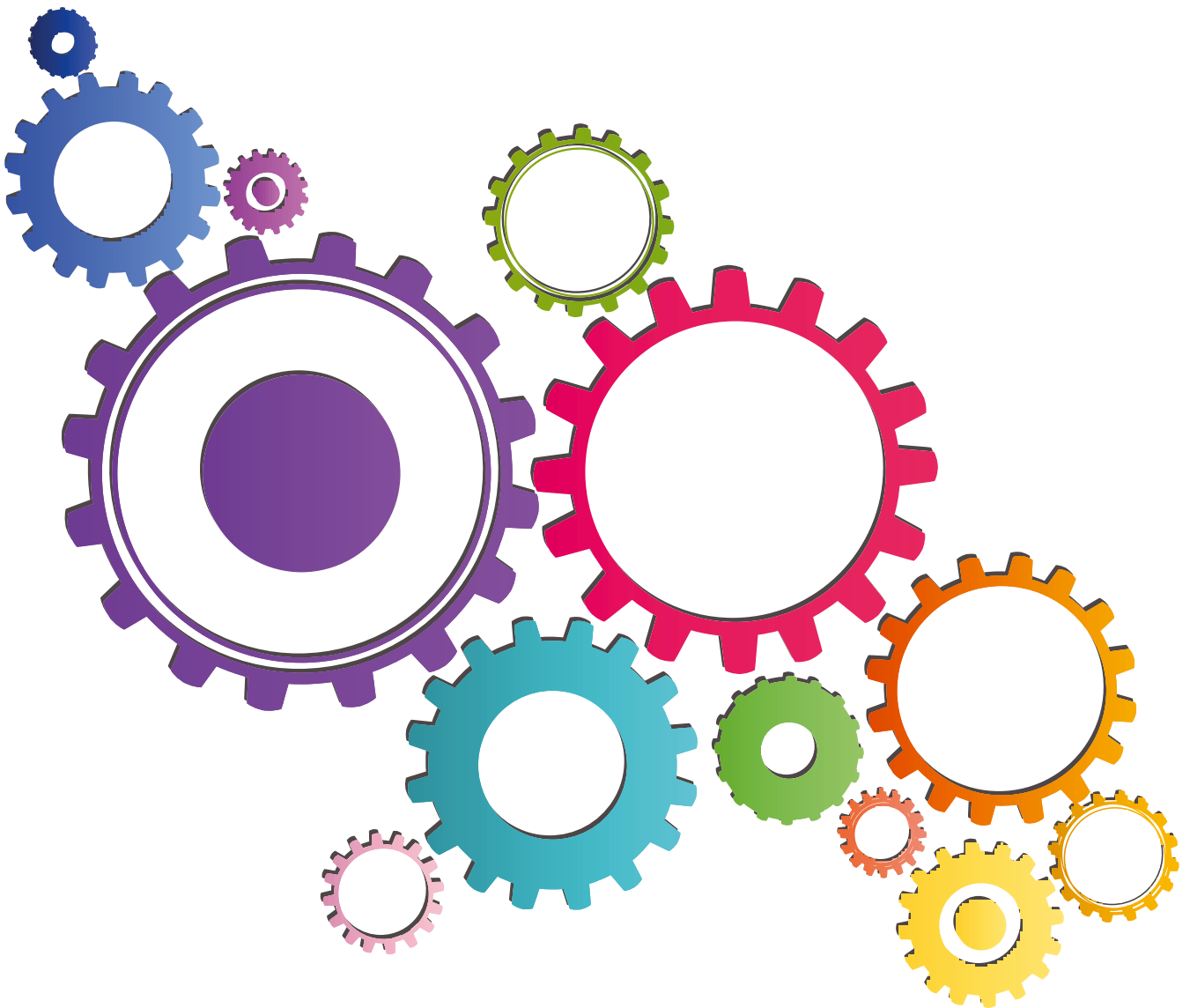


Public Health
England

Making it work

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

Part 1: Main guide



September 2014 (revised March 2015)



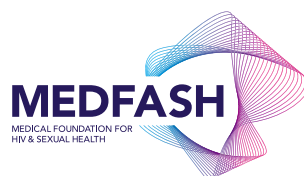
Department
of Health

Local
Government
Association



NHS
England

Prepared on behalf of Public Health England by



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Foreword



Duncan Selbie
Chief Executive, Public Health England

Sexual health, reproductive health and HIV services make an important contribution to the health of the individuals and communities they serve. Their success depends on the whole system - commissioners, providers and wider stakeholders - working together to make these services as responsive, relevant and as easy to use as possible and ultimately to improve the public's health.

This collective responsibility, to maintain and improve integrated services that meet the needs and preferences of users, is particularly important in times of change and I hope that commissioners will find this practical guide helpful. The guide focuses on establishing seamless, integrated care pathways through taking a whole system approach, and describes how this can be made to work in practice.

The economic climate and pressure on resources are encouraging everyone to explore new approaches and opportunities that can deliver better outcomes and better value. The guide includes an examination of how this can happen in practice.

This is not a straightforward task. Whole system commissioning requires a commitment to meticulous collaboration, an alignment of values and principles, an agreement on processes and mechanisms and a willingness to work differently.

There will not be one way to do this. Local areas will design the structures that best suit them, through both formal arrangements and other collaborative approaches. The guide also describes models of existing and emerging practice, which we hope will provide valuable insights - not only for commissioners but also for providers, clinicians, patients and the public.

We would not have been able to share these ideas had we not received support in producing this guide from a range of partners and we are grateful to the Local Government Association, NHS England, the Department of Health, the Association of Directors of Public Health and the wide range of stakeholders across the sector who contributed to it.

If the guide has a key message it is that best outcomes for people and for populations depend on effective collaboration and cooperation. We will get there faster when we share our experiences of integrated working and I hope this guide serves as a significant contribution towards making this a reality everywhere.

Best wishes, Duncan

Key messages

- ✓ Put people at the centre of commissioning, and base decisions on assessed needs
- ✓ Take service user pathways as the starting point for commissioning, with the aim of ensuring people experience integrated, responsive services
- ✓ Review whether existing service provision and configuration best meet identified needs for the area
- ✓ Maximise opportunities to tackle the wider determinants of health
- ✓ Build on the director of public health's role to deliver system stability and integration across the sector
- ✓ Draw on the expertise of clinicians and service users, and the public's views, to inform commissioning
- ✓ Build trust across commissioning organisations by developing strong relationships and dialogue with counterparts to develop local solutions
- ✓ Collaborate - a larger commissioning footprint can make the best use of limited resources to improve outcomes
- ✓ Document the approach to collaborative working, with clearly defined individual and collective responsibilities
- ✓ Ensure commissioned services have the capacity to educate and train the current and future workforce
- ✓ Acknowledge the economic climate requires new thinking and innovation – doing more or less of the same may not radically change outcomes or provide better value
- ✓ There is no one right way – it is for local teams to make collaborative commissioning for sexual health, reproductive health and HIV a local reality

Section 1. Purpose of this document

This guide is for commissioners of sexual health, reproductive health and HIV services in local government, clinical commissioning groups (CCGs) and NHS England.

The fields of sexual health, sexually transmitted infection (STI), contraception, reproductive health and HIV are frequently interwoven at individual, population and service delivery levels, yet each is separate and has its own defining features and interfaces. Different elements have different commissioning arrangements which adds to the complexity. To reflect this and ensure that the guide accurately reflects and engages with this reality the term “sexual health, reproductive health and HIV” abbreviated to “SH, RH & HIV” is used to refer to the whole system. We use each term separately where issues relate to only one area. Although unwieldy, this approach reinforces the point that the system is made up of different elements all of which must be considered when making commissioning decisions. The terms refer to the themes and elements of the system, not to any specific clinical specialty.

The guide has been developed to support commissioning bodies to ensure the delivery of high quality SH, RH & HIV services, in line with their responsibilities set out in the Health and Social Care Act 2012.¹

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.

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 how local areas are 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

It is not intended as a general guide to “how to commission services”; nor does it specify what services need to be commissioned, which should 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). Notwithstanding the range of information outlined in the annexes, the guide cannot provide a definitive answer where policy leaves scope for local determination.

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]
- demonstrate models of existing and emerging practice to illustrate how commissioners are working collaboratively to meet the needs of their particular local populations and communities and address health inequalities [Case studies]
- 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 SH, RH & 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]

Quotes from interviewees are interspersed throughout the document. They represent the voice of those engaged in working collaboratively to meet the challenges and opportunities outlined in the guide.

Section 2. Who does what? Responsibilities for commissioning sexual health, reproductive health and HIV

This section:

- outlines the commissioning responsibilities of local government, CCGs and NHS England for SH, RH & HIV
- describes the principles underpinning the commissioning responsibilities

The commissioning responsibilities of local government, CCGs and NHS England are set out in the Health and Social Care Act 2012.² Additionally, 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 2013.³ These mandate local authorities to commission confidential, open access services for STIsⁱ and contraception as well as reasonable access to all methods of contraception.

Since April 2013, commissioning for SH, RH & HIV has been organised as outlined in Figure 1 on pages 11 to 13.

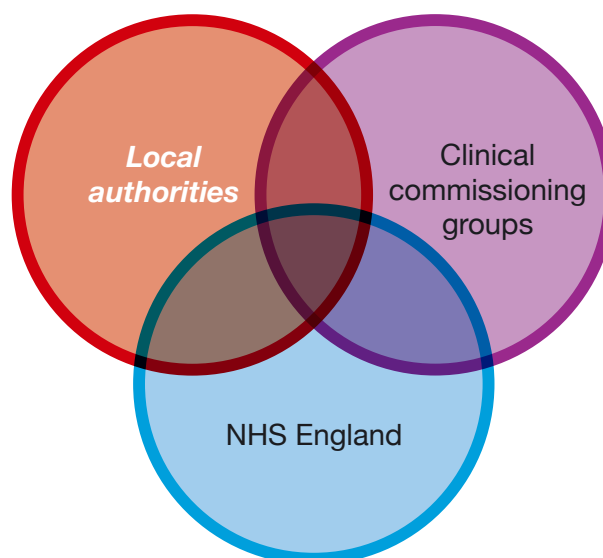
General principles which underpin these arrangements are as follows.

1. 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.
2. Where a commissioning body is responsible for an area of care, they retain this responsibility regardless of the patient's healthcare status. For example, local government is responsible for STI testing of all those attending open access services, including people living with HIV (whereas NHS England is responsible for HIV specialised treatment and care). NHS England, through the GP contract, is responsible for primary care provided by general practice to people living with HIV, as for the rest of the population.

These are general principles and they can be flexed when it makes practical sense to do so. Any such flexibilities must be with the agreement of all parties involved.

i. The prevention and diagnosis of all STIs including HIV; and the treatment and care of all STIs except HIV

Figure 1. Commissioning arrangements from April 2013



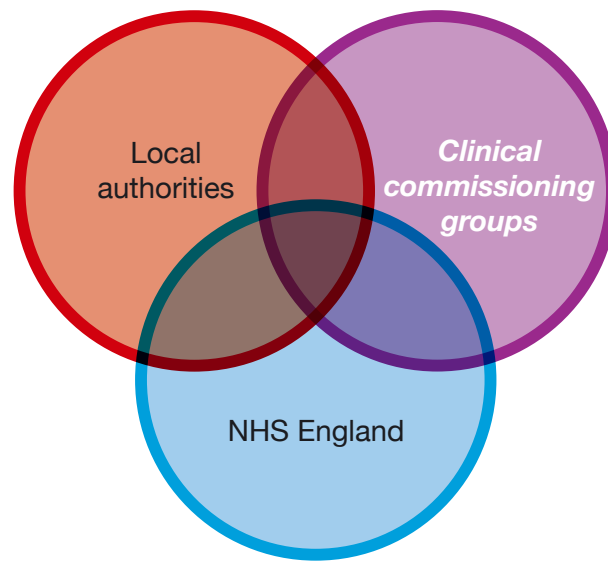
Local authorities commission

- Comprehensive sexual health services. These include:
 1. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)
 2. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settingsⁱⁱ, partner notification for STIs and HIV
 3. Sexual health aspects of psychosexual counselling
 4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmaciesⁱⁱⁱ
- Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:
 1. HIV social care
 2. Wider support for teenage parents

ii. In line with national public health guidance (NICE, 2011) on increasing uptake of HIV testing among black Africans in England (PH33) and men who have sex with men (PH34), and UK national guidelines for HIV testing (BHIVA, 2008) – see Annex 1 for full references.

iii. Sexual health services will be commissioned and funded by local authorities and can be accessed by members of the armed forces and their families - see www.england.nhs.uk/wp-content/uploads/2013/03/armed-forces-com.pdf para 66, p24.

Figure 1. Commissioning arrangements from April 2013

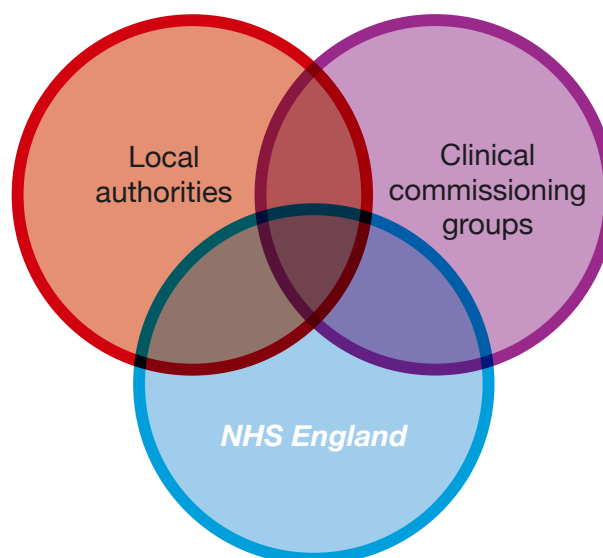


Clinical commissioning groups commission

- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see “NHS England commissions”)
- Female sterilisation
- Vasectomy (male sterilisation)
- Non-sexual health elements of psychosexual health services
- Contraception primarily for gynaecological (non-contraceptive) purposes
- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)

“Commissioning can only really be done effectively in collaboration with providers.”

Figure 1. Commissioning arrangements from April 2013



NHS England commissions

- Contraceptive services provided as an "additional service" under the GP contract
- HIV treatment and care services for adults and children, and cost of all antiretroviral treatment^{iv}
- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (ie not part of public health commissioned services, but relating to the individual's care)^v
- HIV testing when clinically indicated in other NHS England-commissioned services
- All sexual health elements of healthcare in secure and detained settings^{vi}
- Sexual assault referral centres
- Cervical screening in a range of settings
- HPV immunisation programme
- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
- NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

iv. NHS England's HIV Clinical Reference Group is drafting a policy on treatment as prevention (TasP) for consideration as part of the 2015/16 commissioning round.

v. If GP practices undertake this as part of essential services, NHS England is the commissioner.

vi. 'The National Partnership Agreement between The National Offender Management Service (NOMS), NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services' covers establishments commissioned or managed by NOMS including youth offender institutions and immigration removal centres - for further details see www.justice.gov.uk/downloads/about/noms/work-with-partners/national-partnership-agreement-commissioning-delivery-healthcare-prisons2013.pdf (2014/15 version in development).

Local authorities are responsible for commissioning a number of other services, such as social care, drug and alcohol services, family support, education, and housing, which can have a close link to sexual health. Sex and relationships education (SRE) in schools and colleges, for example, is often collaboratively delivered with school nursing and input from sexual health services. Likewise, NHS England and CCGs have other commissioning responsibilities that interface closely with SH, RH & HIV, for example, general practice, gynaecology and mental health services.

Local authorities and CCGs commission services and prevention interventions on a population basis. NHS England has specialised commissioning hubs based in area teams (ATs) which directly commission specialised services, including HIV treatment and care, on a provider basis within a national specification.⁴ The planning of prevention, treatment and care needs to link effectively and seamlessly across these commissioning organisations. NHS England's single operating model also applies to its other directly commissioned services such as sexual assault referral centres (SARCs), the NHS Infectious Diseases in Pregnancy Screening Programme and the cervical screening programme.

NHS England's ATs commission primary care on a registered population basis. GPs and primary care nurses have an important role in SH, RH & HIV. Most GP practices are commissioned to provide contraceptive services, sexual health promotion and referral to specialist sexual health services as an "additional service" within the standard GP contract (see Figure 2). GP practices may also be commissioned by local government to provide intrauterine contraceptive devices (IUCDs) and contraceptive implants, and more comprehensive STI testing and treatment services, through public health contracts.

The differing starting points of the commissioning models in local government, CCGs and NHS England represent a risk for fragmentation of the care pathway for service users or a lack of integration between prevention, treatment and care. This reinforces the need for a whole system perspective and a collaborative approach to designing and commissioning care pathways locally, as well as linking local prevention activities to national prevention programmes.

Wherever commissioning responsibilities lie, sexual health, reproductive health and HIV will always be a complex and fascinating area at the intersection of population health and individual healthcare and intertwined with other areas as diverse 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.

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 SH, RH & HIV, relevant health and social care legislation and legal mechanisms to support commissioning
- Annex 4 gives further details on the structure of NHS England

Figure 2. Contraceptive services as an “additional service” in the standard GP contract

<p>NHS England commissions - the contraceptive services commissioned by NHS England 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

DID YOU KNOW?

- an estimated £630m was spent in 2012/3 on HIV treatment and care⁵
- 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 year⁶

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

This section:

- offers a definition of “whole system commissioning”
- describes effective commissioning in SH, RH & 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

Service users' needs for integrated pathways are at the heart of the case for whole system commissioning. Following an HIV diagnosis, for example, it is essential to refer the patient to specialised services for a rapid assessment of clinical and immunological factors to formulate, with the patient, an appropriate, individualised treatment and monitoring package. As another example, 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 increases the risk of service users falling out of the system which can reduce their treatment adherence and worsen subsequent health outcomes. Disjointed pathways also result in missed opportunities to address people's wider needs, whether they relate to alcohol or drug use, domestic violence or building self-esteem.

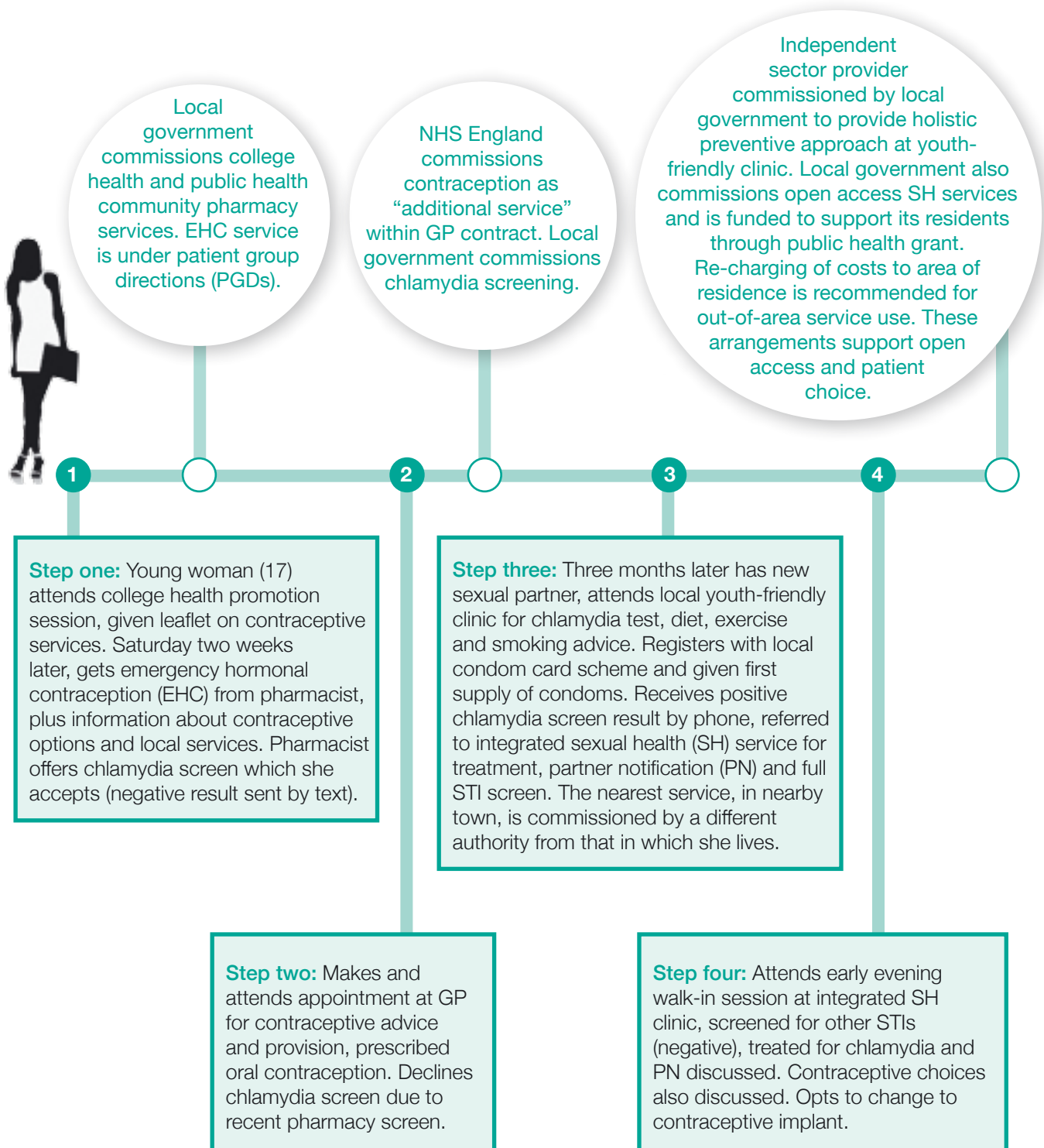
“Whole system commissioning” is an emerging term in health and social care and in developing this guide we offer the following definition which draws on work undertaken in Scotland by the Social Work Inspection Agency.⁷ “A whole system approach to commissioning takes a broad view across the full range of responsibilities undertaken by commissioners in local authorities (including public health, social care, education, leisure and recreation) and the NHS. In SH, RH & HIV commissioning, relationships are between NHS England through its specialised services, primary care and public health commissioners, clinical commissioning groups (CCGs) and local authority public health and social care departments.”

A whole system approach will focus on the impact of commissioning in terms of outcomes defined in the Public Health and NHS Outcomes Frameworks and the benefits to service users as well as the wider population. Collaboration is essential to develop local commissioning strategies, assess the implications of decisions across the whole system and agree shared pathways that will secure seamless SH, RH & HIV services.

Three journeys illustrate how people might move between SH, RH & HIV services. These are presented not as “best practice” pathways but rather to demonstrate how the services used by one person are closely linked while being commissioned by different organisations. The challenge for commissioners is to ensure people can access appropriate services and interventions along a seamless pathway.

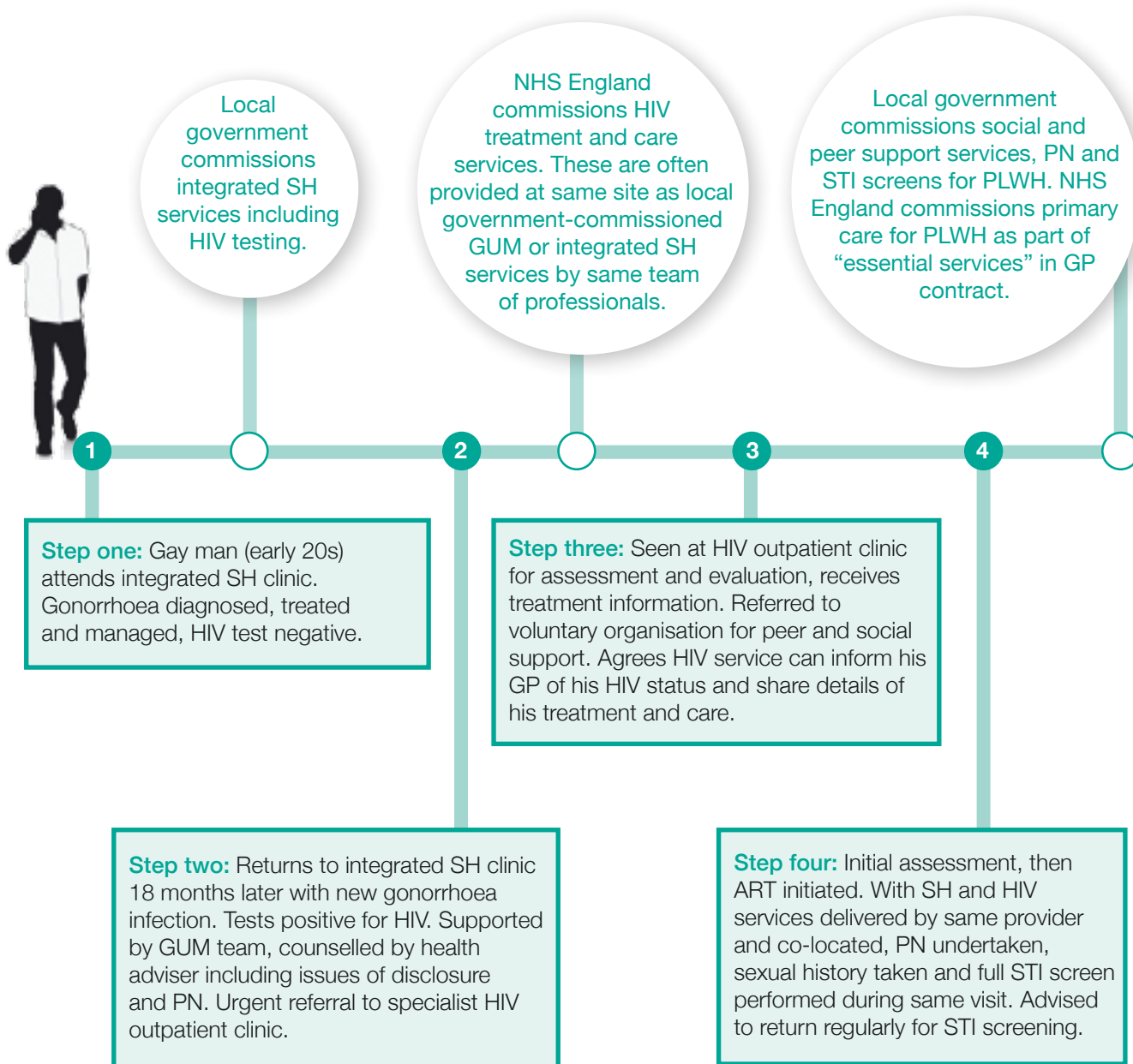
A young woman's journey

The first service user journey describes a young woman's use of open access sexual health services. It illustrates the need to provide information, advice and care that support her positive sexual 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.



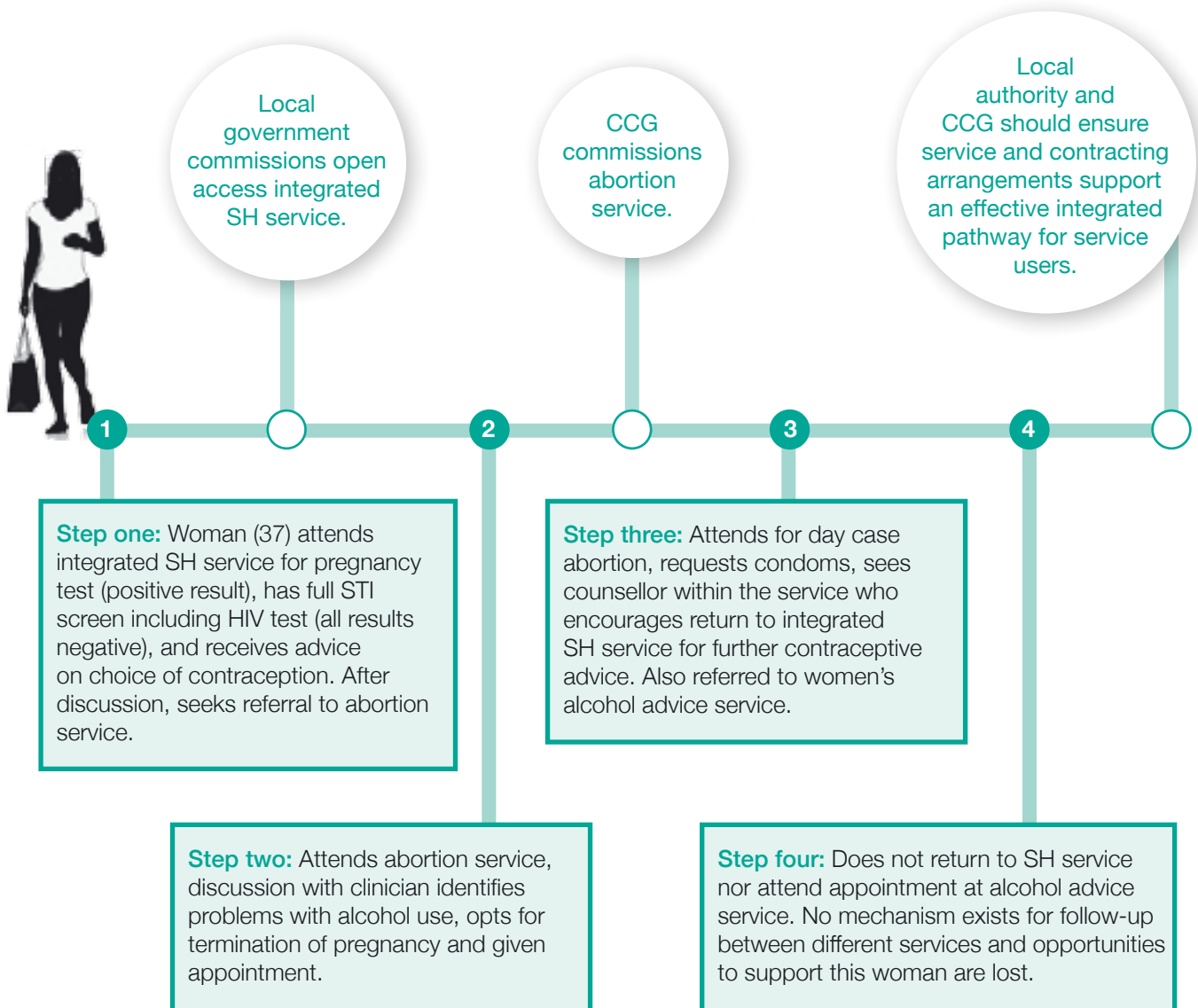
A gay man's journey

The second service user journey describes the sexual health needs of an 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 social support, which they may seek outside their local authority of residence to maintain confidentiality. Flexible funding mechanisms are required which match patterns of service usage.



A woman's journey

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 a range of other, disparate services. The opportunity to meet her needs in an integrated way is therefore lost.



Effective commissioning in sexual health, reproductive health and HIV

Effective commissioning understands and addresses the wider determinants of sexual and reproductive health (such as age, gender, sexuality and cultural, social, educational and economic factors). It also addresses health inequalities and tackles the stigma, discrimination and prejudice often associated with HIV and other sexual and reproductive health matters. Effective commissioning assesses and meets the SH, RH & 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 at risk

There has never been a greater need for organisations to work together, pooling expertise and resources in a collaborative, whole system approach. In doing so the interrelated SH, RH & HIV 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 that collaborative commissioning arrangements are not able to be driven centrally, but must be established locally.

Dialogue within and between organisations is essential as initiatives and plans are developed - for example, as CCGs and local government work together to make every contact count and to integrate health and social care.

Collaboration can ensure service use patterns across pathways are understood, innovation is fostered and best value obtained from limited resources. For example, NHS England colleagues can seek to add value through collaborative commissioning of specialised services, primary care and other relevant directly commissioned services. Similarly, in local authorities, collaboration within and between public health and other departments, such as drug and alcohol services, education, adult social care and children and young people, will further strengthen the impact of commissioning, for example, in sustaining momentum to reduce teenage pregnancies and reducing new HIV infection related to sex and drug use.

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.

To achieve shared commissioning objectives in SH, RH & 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. There needs to be a recognition and understanding of the broad range of interfaces with other commissioners and services, for specific objectives such as reducing rates of teenage conceptions or late diagnosis of HIV to be achieved. Links to education, drug and alcohol services, general practice, mental health services, accident and emergency departments, general medical specialties, maternity, and children and young people services all have a key role to play.

Figure 3. Public Health and NHS Outcomes Frameworks: progress and challenges

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 27.7 (England only) conceptions per thousand women aged 15-17 ⁸ .	Despite the significant reduction in the under 18 conception rate, England continues to have rates higher than comparable western European countries. ⁹ There is considerable variation in progress between local authorities ¹⁰ .

Public Health & NHS Outcomes Framework indicators	Progress	Challenges
<p>People presenting with HIV at a late stage of infection (Public Health Outcomes Framework)</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.¹¹</p> <p>97% of people diagnosed in 2012 were linked to HIV care within three months.¹²</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%.¹³</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.¹⁴</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.¹⁵</p> <p>The 47% of people with HIV who are diagnosed late have a ten-fold increased risk of death in the first year of diagnosis compared to those diagnosed with earlier infection.¹⁶</p>

Public Health Outcomes Framework indicator	Progress	Challenges
Chlamydia diagnosis rate (15-24 year olds)	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). ¹⁷	Fewer young men take chlamydia tests than young women. 37% of young men had a chlamydia test in the past year compared to 57% of young women. ¹⁸

Benefits of investing in a collaborative whole system approach

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 individual and population benefits arising from investment in effective services and interventions
- the requirement to meet population needs across the life course
- the mandate to commission open access services
- economic and technological change.

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

“A focus on the shared public health agenda is key.”

Policy and indicators to support commissioning

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 SH, RH & HIV. ‘A Framework for Sexual Health Improvement in England’, the key policy document for SH, RH & 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.”¹⁹

Investing in effective services and interventions

Investing in effective SH, RH & 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) ✓ = benefit for specified commissioner(s)
<p>Objective: Continue to reduce the rate of under 16 and under 18 conceptions</p> <p>Commissioning intention: Ensure 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 intention: Encourage uptake of chlamydia screening and testing for under 25 year olds</p>	<p>Treatment of STIs</p> <p>Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy)</p>	<p>Reduction in prevalence and transmission of infection</p> <p>Opportunities to test for other STIs/HIV in those diagnosed with chlamydia</p> <p>Reaching young people with broader sexual health messages</p> <p>Increased uptake of condom use</p>	<p>Reduced use of gynaecology services (to manage other health consequences) ✓ CCGs</p> <p>Increased uptake of sexual health services by young people ✓ LAs</p> <p>Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence ✓ LAs</p>

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: Reduce onward transmission of HIV and avoidable deaths from it</p> <p>Commissioning intention: Ensure 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: Ensure 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 child care ✓ LAs</p>

“The key success criteria are: trust, risk sharing arrangements and jointly agreed strategy.”

Commissioning to meet individual and population need across the life course

People's sexual and reproductive health needs vary at different stages in their lives. SH, RH & 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.

The specific needs of high risk and vulnerable groups should be understood and articulated in any needs assessment. Examples of these groups include young people, people with learning and physical difficulties, homeless people, MSM, gay, bisexual and transgender (LGBT) people, people living with HIV, sex workers, substance users, survivors of sexual abuse/domestic violence, people whose first language is not English and people with chronic medical conditions requiring complex contraception advice.

Sexual behaviour and SH, RH & HIV needs are affected by wider social factors and this, in turn, has an impact on the acceptability of services, how they are used and ultimately on health outcomes. Examples of the impact of such wider determinants of health include:

- low educational attainment and teenage pregnancy²⁰
- recreational drug use and STI/HIV²¹ acquisition and transmission risk behaviour
- non-volitional sex at a young age and adverse health outcomes in both men and women²²
- ageing with HIV and evolving needs for social care²³

These wider issues need to be addressed collaboratively by all commissioners across SH, RH & HIV as well as through collaboration between public health and other departments within local government. Directors of public health, working with Public Health England (PHE) colleagues, can advise on the implications of demography, health-seeking behaviour and disease burden for commissioning integrated care pathways and effective interventions and services.

Delivering the mandate to commission open access services

Local authorities are mandated to commission "open access" sexual health services.²⁴ This means people can self-refer to the service of their choice regardless of location. Open access encourages uptake of services in the context of the stigma associated with HIV and sexual ill health. Sexual health services are in the frontline of managing communicable disease, maximising life expectancy and minimising morbidity from HIV through timely diagnosis and referral to specialised HIV services. It is a priority to test as many people as possible for STIs and assure prompt treatment (see case study in Annex 6 on management of communicable disease outbreaks). Open access services also enable positive reproductive health by ensuring women have access to contraception when they need it. Choice is underpinned by the diversity of sexual health and reproductive health provision in primary and secondary care. Some people choose to use services outside their borough for reasons of convenience, accessibility and confidentiality.

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 ten local authorities, 12 CCGs and eight acute trusts (see case study 2).

Economic and technological change

SH, RH & HIV services are at the cutting edge of new technology in healthcare. Given the age profile of service users, there is great potential to maximise the use of advanced health technologies and social media in service development to deliver best value outcomes. Both commissioners and providers need to be able to respond appropriately to these developments. The current resource climate for public services makes cost efficiency a requirement and puts cost effectiveness under close scrutiny.

Change will be driven by two pressures: evolving needs on one hand and reductions in funding and resources 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.

The transaction costs of multiple commissioning relationships with individual providers are potentially high. Collaborative commissioning, especially across a larger geographic footprint, makes sense.

DID YOU KNOW?

- long-acting reversible contraception (LARC) methods are more clinically and cost effective than the combined oral contraceptive pill even at 1 year of use²⁵
- the intrauterine device (IUD), the intrauterine system (IUS) and the contraceptive implant are more cost effective than injectable contraceptives²⁶
- the annual net saving from increased use of LARC would be £102m²⁷

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

This section:

- identifies the leadership role of directors of public health (DsPH) 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

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

- **establish responsibility and leadership** – DsPH agree with senior CCG and NHS England colleagues a lead who will oversee and co-ordinate across the whole local system of SH, RH & 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 SH, RH & 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 director of public health (DPH), reporting to the health and wellbeing board (HWB) and/or a local commissioners' forum, or funding arrangements such as pooled budgets and/or section 75 agreements

Many areas already have such arrangements and examples are described in the case studies. Annex 2 gives 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.

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

Mechanism 1: local system leadership

The arrangements put in place by the Health and Social Care Act 2012 require a collaborative approach. The Act 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.

“If the healthcare public health service is to be effective there will need to be constructive relationships built between local authorities and CCGs, to ensure that the local commissioning fully reflects the population perspective. The key to making it work will be developing effective local partnerships. The role and strategic leadership of the Director of Public Health will be to build collaborative relationships across the commissioning landscape”.

Source: DH Public Health Development Unit, HI&P Healthcare Public Health Advice Service to Clinical Commissioning Groups: Guidance to support the provision of healthcare public health advice to CCGs. June 2012.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/216835/Healthcare-Public-Health-Advice-Service-Guidance-FINAL.pdf

“A lot is around relationships – need excellent ones to work together.”

Lever: health and wellbeing boards

Health and wellbeing boards (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 and 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 and hold commissioners accountable for delivering them.

Lever: role of directors of public health

A key role of directors of public health (DsPH) is leadership to hold the system together and enable it to deliver on shared strategic objectives set by HWBs. This is highlighted in Department of Health (DH) guidance²⁸ on their roles and responsibilities that states DsPH: “contribute to and influence the work of NHS commissioners, helping to lead a whole system approach across the public sector.”

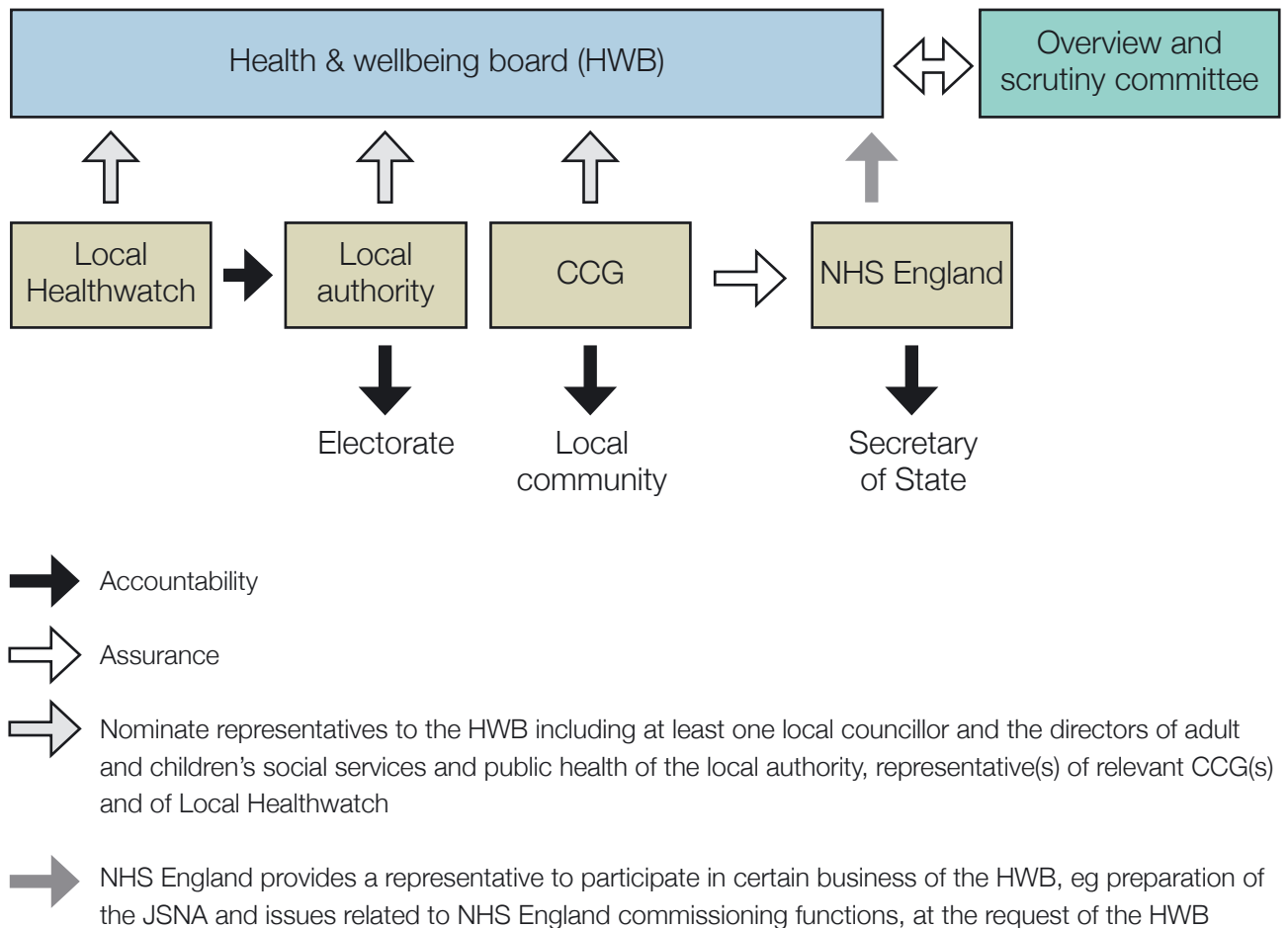
DsPH and their teams also deliver the local authority’s mandated function to advise CCGs on population health which will inform and strengthen their commissioning decisions. Local authorities (and DsPH who would usually act on their behalf) have a critical role in protecting and improving the health of their populations^{29 30}.

Local commissioning partners are best placed to determine how to deliver a whole system approach for SH, RH & HIV. DsPH 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 approaches to meet population need and deliver integrated care pathways across the system. Public health specialists, as commissioners, have a key role in providing evidence on the potential consequences of commissioning decisions, including cost effectiveness, and in leading service redesign.

Lever: PHE centres and intelligence hubs

As well as advising NHS England, 15 PHE centres and eight intelligence hubs work with the local system (see Annex 5). They can offer intelligence and expertise and share experience from a regional and national perspective. As such they are well placed to contribute to collaborative whole system commissioning.

Figure 5. Governance and accountability



“People on the ground – professionals who have done the work need to be listened to.”

Mechanism 2: values and principles

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 build clear and collaborative communication.

'A Framework for Sexual Health Improvement in England'³¹ outlines principles of best practice in SH, RH & HIV 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 agreed between the local authority and CCG (see case study 1).

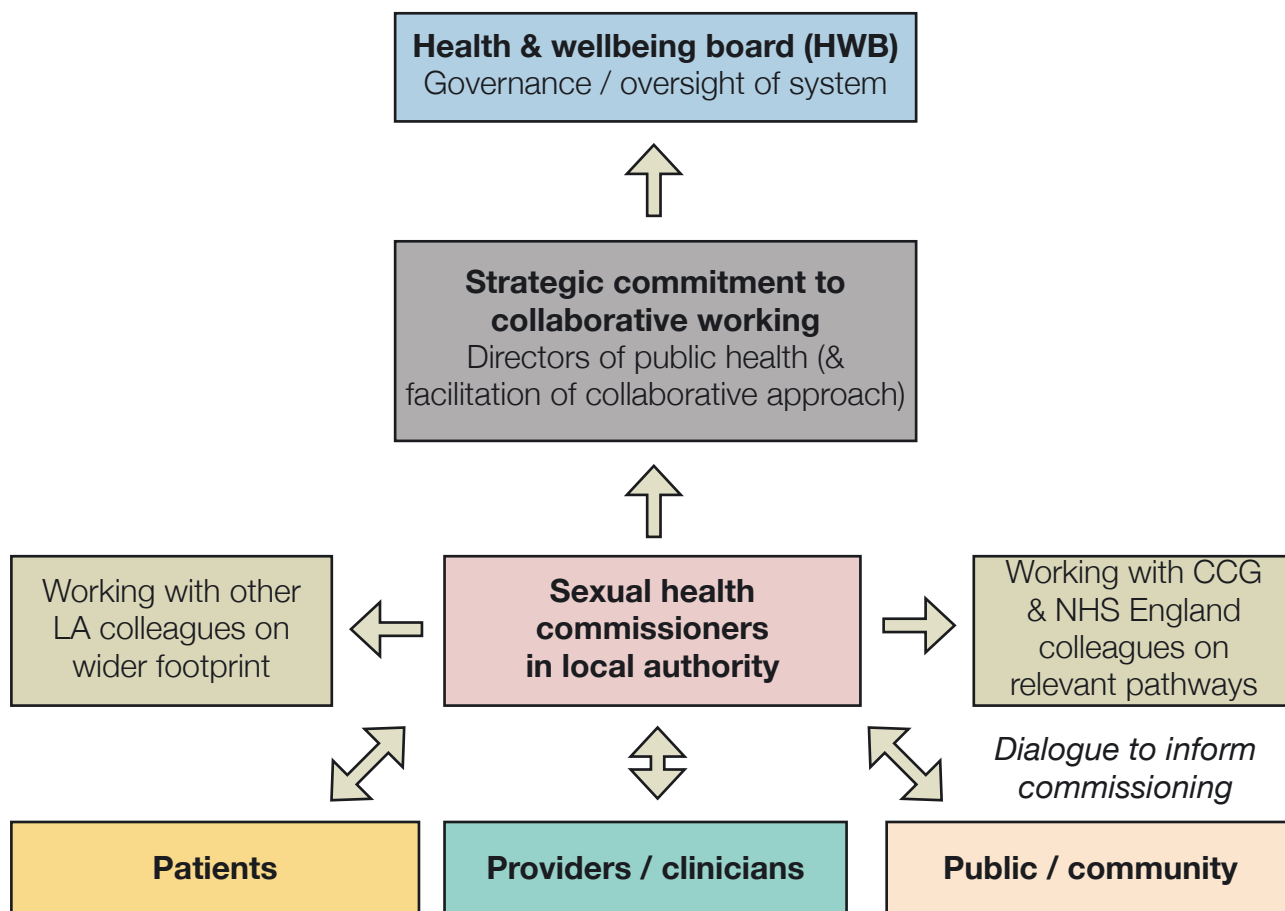
“No-one’s going to come and sort it out for us... It’s down to us.”

Mechanism 3: pathways and interdependencies

As illustrated in Section 3, all commissioners need to understand how people access and move between different SH, RH & HIV services including primary care. To achieve this, they should assess and understand need and document the linkages and referral patterns between services. Commissioners also need to understand how service delivery is linked in terms of workforce, clinical expertise, information technology and data collection, for example in co-located HIV and genitourinary medicine (GUM) services. All stages of commissioning including redesigning services, drawing up specifications, setting standards and tendering, should be informed by a collaborative assessment of these interdependencies.

Commissioners need to analyse how decisions taken by one organisation may affect other services in the system and explore any risks to patient care. In a whole system approach commissioners jointly assess and test the impact of plans across the system at key points in the commissioning cycle, for example, prior to procurement decisions. Commissioning decisions related to GUM services may impact on HIV treatment and care services or go beyond this 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. They need to take account of current service delivery patterns and the benefits of maintaining co-location where risks to patient care and outcomes have been identified if services are moved apart.

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



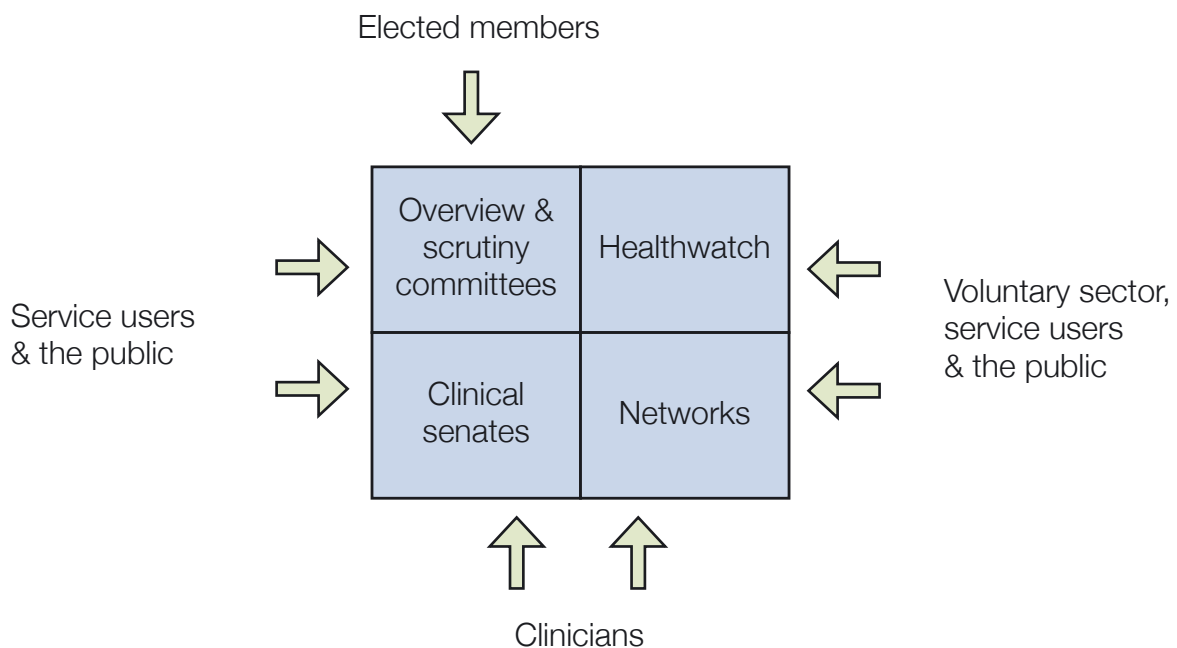
“Involve patients and staff in service redesign and commissioning across the whole system.”

Mechanism 4: engagement and participation

Effective commissioners engage and consult widely with clinicians, provider organisations, the voluntary sector, service users and the public. Clinicians and providers can help shape solutions to commissioning challenges. Service users and local residents have influence in local political systems and on local government decisions. Figure 7 highlights roles, structures and processes 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 outlined on the following pages and their contribution described in several of the case studies.

“I personally have learnt over the last 12-18 months the power of working in partnership with my health and care colleagues locally – providers, other commissioners, local authority colleagues and others – to co-design our vision for the future of our health economy, with an opportunity to truly put citizen outcomes at the heart of everything we do.”
Chief Clinical Officer of CCG

Figure 7. Participants in the range of levers for whole system commissioning



Lever: overview and scrutiny committees

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

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 (HWB) 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

Clinical senates were set up to help CCGs, local authority HWBs 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.

“Commission work to get patients more involved and secure a picture of the gaps.”

Lever: networks

Provider networks for SH, RH & HIV exist in some areas. They bring together providers for service delivery and can act as a focus for sharing intelligence and providing advice, education and training, setting and maintaining standards and developing shared pathways and protocols. The NHS England specification for specialised HIV services requires providers to establish formalised networked arrangements to balance quality of care, productivity and access. HIV networks can also be an effective mechanism for harnessing system leadership particularly in relation to HIV treatment services. In addition, networks can 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). A number of existing networks are funded by commissioners.

Support to a whole system commissioning approach is also provided through the English Sexual Health and HIV Commissioners Group (see case study 15).

Checklist

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 SH, RH & 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)

DID YOU KNOW?

- partner notification (PN) is an effective strategy for diagnosing HIV
- a fifth of sexual contacts tested following PN were newly diagnosed with HIV³²
- PN soon after seroconversion (ie in the first few months after infection) has a higher pick-up rate of people with new positive diagnoses³³

Section 5. How to work collaboratively to deliver improved outcomes

This section:

- outlines how to commission collaboratively for better outcomes
- proposes local actions to address whole system commissioning issues

How to commission collaboratively

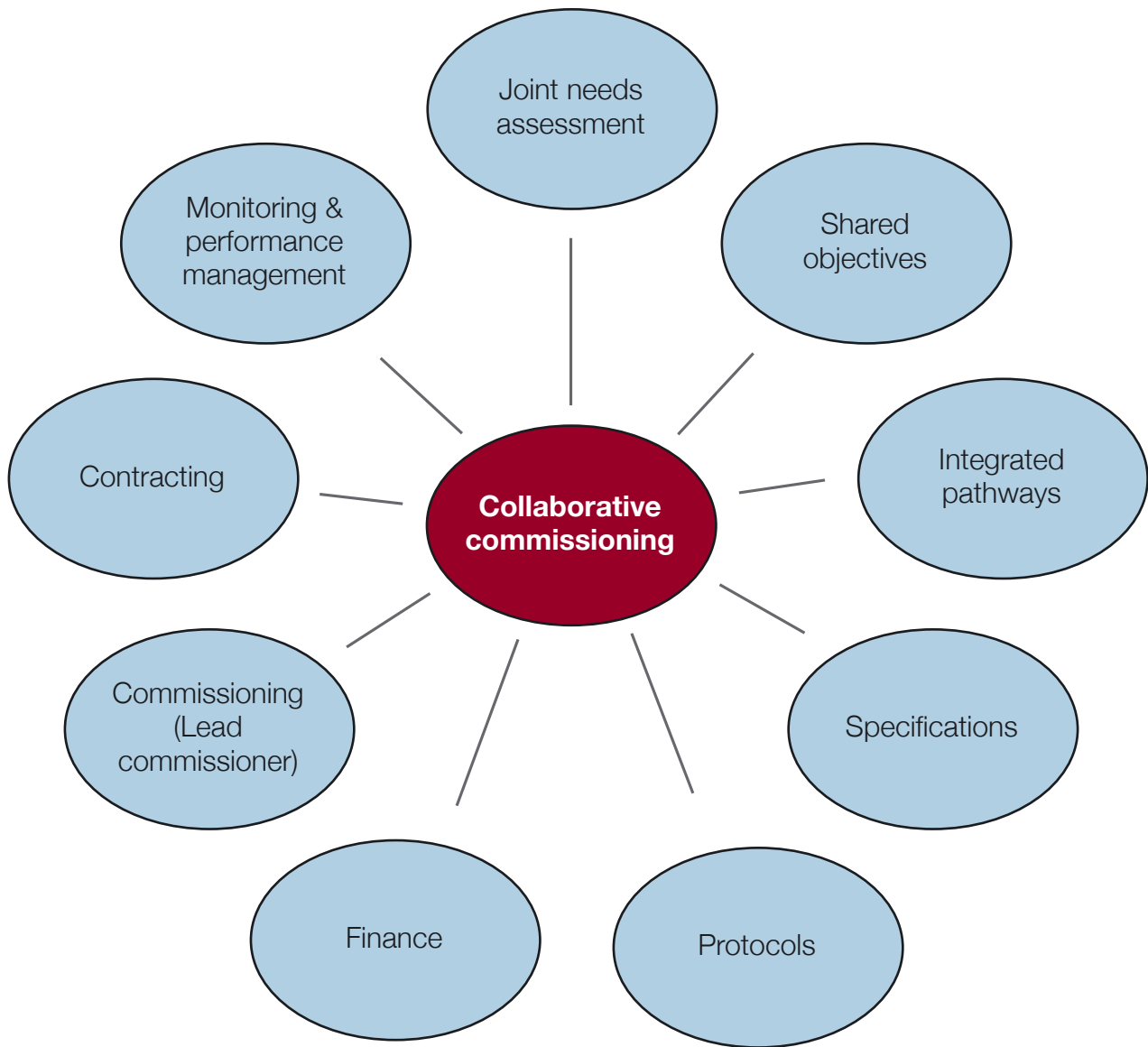
Whole system commissioning takes local system leadership and collaborative approaches at all levels. It also requires clarity on how funding follows the service user, how tendering and contracting will operate, the shared development of service specifications and agreement on standards, outcomes, data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

There is no one right way to do this. Commissioners are best placed to judge how to tailor actions to meet commissioning challenges to their local context. The case studies presented in this guide share practical experiences from commissioners in both urban and non-urban settings in developing collaborative commissioning models and practices. The local actions proposed in this section focus on:

1. building collaborative commissioning arrangements
2. securing stakeholder engagement
3. securing best value
4. developing collaborative funding arrangements
5. managing procurement
6. implementing change
7. driving quality improvement and service development

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

Figure 8. Elements of collaborative commissioning



1. Building collaborative commissioning

✓ *Establish formal working relationships*

Arrangements between local authorities

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, six unitary authorities have established a shared team to manage the new public health responsibilities, including commissioning sexual health services (see case study 5). In North West London, nine local authorities are collaboratively commissioning GUM services (see case study 8).

Arrangements across a geographical area

Assess the case for a unified framework for commissioning SH, RH & HIV services, whether across a smaller or larger geographical area. This should 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. Consider the implications of such a framework for both contraception and STI management, and how it can support the commissioning of integrated sexual health 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 and plan how to remove or, where necessary, mitigate and jointly manage the short and longer-term risks.

Linked business processes

Build close collaboration between commissioners and colleagues from finance, legal and procurement departments of different organisations. Allow plenty of time to develop successful collaborative commissioning arrangements and associated financial, tendering and contracting processes.

Make sure arrangements are appropriately 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

People's SH, RH & HIV needs are linked, as are the services required to meet them (see Section 3). Planning for each area of care has implications for the others. Make sure that all commissioners have a clear understanding of these interdependencies including care pathways, services and provider relationships. All of these should be informed by a joint needs assessment.

Interdependence between HIV and GUM

Be alert to, and take account of, the critical interdependencies between GUM and HIV outpatient clinics, which are often co-located and co-provided. NHS England specialised commissioners in ATs and local authority sexual health commissioners should assess these links, notably clinical expertise, training and education, and infrastructure. As commissioners in ATs implement NHS England's service specification for HIV care and treatment, any potential changes in provisions should be worked through with other local commissioners to avoid destabilisation of existing services and ensure care pathways are maintained. Where sexual health commissioners have plans to market test, these should be shared at an early stage with NHS England colleagues. NHS England ATs have put in place arrangements to enable collaboration with colleagues in local authorities and PHE centres, supported by the accountable commissioner for the HIV Clinical Reference Group (CRG) (see case study 9). Given the interdependencies between HIV treatment and care services and sexual health services, especially for some high risk groups such as men who have sex with men (MSM), the benefits of continued co-location of these functions, and the benefits of a single provider commissioned by more than one body, should be considered.

2. Securing stakeholder engagement

✓ *Engage effectively with local political leaders*

Roles of political leaders

Recognise the valuable contribution local political leaders bring to collaborative commissioning in SH, RH & 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

Elected members can act as strong advocates for SH, RH & HIV. Ensuring they understand local needs, and the contribution services can make to tackling those needs, is essential to this process.

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).

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 SH, RH & HIV issues through health and wellbeing boards, council committees, scrutiny exercises and community engagement processes. These should explore 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 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

Work with Local Healthwatch, SH, RH & 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). A range of approaches is needed to capture the views of actual and potential service users, as well as representative voices.

3. Securing best value

✓ *Take a multi-pronged approach*

Payment mechanisms

Establish local criteria to assess which payment mechanisms provide best value. The benefits of tariffs are articulated in 'Sexual Health Commissioning: Frequently Asked Questions'³⁴. Commissioners may choose to use the integrated sexual health tariff or develop local tariffs for GUM, sexual and reproductive health (SRH) or integrated sexual health services. Commissioners in Leicester, Leicestershire and Rutland aimed to introduce an integrated sexual health tariff to generate savings (see case study 10). Both block and tariff arrangements can deliver value for money and high quality services, depending on how they are structured and managed.

Cross-charging

The Advisory Committee on Resource Allocation (ACRA) has expressed the view that cross-charging is the best way to handle use of sexual health services by residents of other local authorities. Existing documents^{35 36} provide further information on cross-charging, including the suggestion that if the two-way patient flows between two areas are 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 patient flow between the two areas. Some local authorities are considering adopting this approach across a number of authorities.

Savings through collaboration

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

Identify how collaborative commissioning can enable efficiencies in specific areas of care. Savings generated in one area can be reinvested across the system.

Funding strategy

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

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

Understand the factors influencing future funding, 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

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

- reviewing current service provision and assessing whether it best meets identified needs
- service redesign (see case study 6)
- targeted training such as LARC or dual training in sexual and reproductive health
- investing in prevention
- reviewing case mix across different services and identifying how and where differing levels of need are best met, including in primary care
- using benchmarking to review service costs with providers
- online services and use of information technology including social media

4. Developing collaborative funding arrangements

✓ *Explore options*

Collaborative funding approaches

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.

Different approaches to contracting on behalf of two or more commissioning bodies are summarised in Figure 9, demonstrating that a variety of options are available to commissioners which can be matched to local circumstances (see case studies 2, 6, 7 and 8).

“Sometimes you need to get out the ‘too hard to do’ box and try to get some of the things in it done.”

Figure 9. Options for contracting on behalf of multiple commissioners

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

✓ *Agree shared funding arrangements*

Written agreements

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

Consider developing partnership arrangements, including the option of fully integrated services with commissioner pooled budgets via section 75 agreements. Whilst NHS England cannot enter into section 75 agreements in commissioning primary medical services, NHS England is able to enter into section 75 agreements that support a fully integrated approach including the joint commissioning of sexual health services with local authority partners³⁷. The collaborating bodies need to agree on lead commissioning arrangements as well as the contract to use, based on legal advice to all parties. Local authorities and CCGs already have experience of this approach to address other health needs (see further information and case study in Annex 2).

5. Managing procurement

✓ *Secure clinical engagement without compromising transparent procurement*

Boundaries for engagement

Identify clear boundaries for provider and 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. Local providers and 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 specialised HIV services for adults and children.

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 lists of members willing to offer local authorities expert clinical input into sexual health contracting processes. Commissioners in Leicester, Leicestershire and Rutland found that engaging external facilitators gave credibility to their service redesign process (see case studies 5 and 10).

Further advice on tendering and procurement

Further advice on this and other tendering and procurement issues can be found in the ‘HIV, Sexual and Reproductive Health: Current Issues Bulletin 4’³⁸.

✓ *Manage the market*

Needs-based procurement

Base decisions about procurement on a thorough SH, RH & HIV needs assessment (which builds on the JSNA) and a review of current services. Consider the entire pathway of prevention, treatment and care, including primary prevention services such as sex and relationships education and ensure the needs of specific groups are catered for (see Section 3, page 26).

Collaboration to manage risk

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

Shared learning

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

Market stimulation

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 applies especially where the service specification requires providers to demonstrate how they would meet the needs of vulnerable and hard to reach groups. Such events can encourage a diversity of potential providers, for example where voluntary sector providers might appropriately bid to provide an element of the service.

“Patients come first...they are the ones that matter and it's our responsibility to find solutions.”

6. Implementing change

✓ *Create a sustainable workforce*

Education and training

Define in service specifications what is required of providers to enable education and training for the whole workforce. A trained and skilled workforce is vital to the delivery of high quality SH, RH & HIV services. Commissioners should support the capacity to develop current and future generations of doctors, nurses, sexual health advisers and other relevant professional groups.

Safeguarding the future workforce

Make yourself aware of education and training issues for specialists and non-specialists where SH, RH & HIV services play a significant role. Planning and funding of training provision is the responsibility of the local education and training boards (LETBs). There are 13 LETBs relating to Health Education England and commissioners should be aware of the LETB to which their services relate. Providers employ the trainees and receive funding from LETBs based on a Learning Development Agreement. Be aware that training in genitourinary medicine (GUM) requires experience in either GUM or integrated sexual health together with specialised HIV inpatient and outpatient services. In developing service specifications, engage at an early stage with local academic and training institutions, LETBs and any local training advisers in SH, RH & HIV, such as those from the FSRH or BASHH, for expert advice. Including the number of training posts in tendering specifications allows bidders to assess the financial implications and ensures commissioners compare like with like. The team evaluating the tenders can include relevant expertise in training and education. In Leicestershire this was provided by the LETB (see case study 10).

Training for qualified professionals

Ensure that training is supported for qualified professionals to deliver services under all contracts, for example LARC fitting for contraceptive and non-contraceptive purposes in all relevant settings, specialist training for healthcare professionals providing termination of pregnancy services or provision of emergency hormonal contraception in pharmacies. Primary care clinicians developing and maintaining their post-registration competence and accreditation facilitates diversity and choice for women in contraceptive methods. Secondary care staff developing and maintaining their post-registration competence and accreditation supports the provision of integrated care pathways for service users. Commissioners should seek advice from the LETB about how they can support such training provision and work together to identify funding sources to meet training needs.

✓ *Manage de-commissioning and mobilisation*

Opportunities to review service provision

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 and require redesign. Alternatively, 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

Recognise that each set of circumstances in which services are de-commissioned and new services mobilised is unique. The established principles of change management apply. 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 facilitate the new provider, for example, intended use of existing premises

Infrastructure and key staff

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 roles and responsibilities of posts within the incumbent provider where time is split between services commissioned by different bodies. Examples include GUM clinicians providing both integrated sexual health and specialised HIV care. Clarify their future availability, roles and responsibilities if one of these aspects of care were to be moved to a new provider

7. Driving quality improvement and service development

✓ *Support evidence-based practice and service development*

Research and development

Recognise the importance of research and development in driving improvements in HIV clinical care and in the modernisation of SH, RH & HIV services. NHS England states 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”.³⁹ Commissioners should welcome provider participation in clinical studies and in operational research and evaluation and ensure that commissioning of services does not impede participation. These may be funded and led by the National Institute for Health Research (NIHR), Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) and academic health science centres.

Evidence-based commissioning

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 universities. Share research findings between commissioners and providers through established networks and forums. The financial implications of implementing research evidence need to be explicitly discussed and agreed.

✓ *Agree a joint approach to quality improvement*

Shared specifications and standards

Driving improvement in quality and outcomes across an 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 the standards and outcomes to be achieved. These should draw on both national standards and outcomes frameworks and research and audit.

Measuring outcomes

Agree ways of measuring quality and outcomes across the local system. Monitor services against baseline indicators from the strategic needs assessment and the identified quality measures. Where research and evaluation activities are linked to the identified quality and outcome measures, the findings should be widely disseminated.

Data sharing

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 as well as compliance with information governance rules and rules about data on users of SH, RH & HIV services. 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). Working together to specify data requirements also helps ensure effective payment mechanisms. Clear datasets help reduce the risk of gaps in activity reporting or duplication of invoicing to multiple commissioners. It also ensures that any benchmarking of services is based on data collected to a common definition.

Performance monitoring

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. It can also facilitate 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

Build on public health activities to foster collaboration across commissioning organisations and services. As recommended in 'A Framework for Sexual Health Improvement in England'⁴⁰, building the prevention role of the wider non-health workforce into commissioning is beneficial. 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 (see case study 12). Linking SH, RH & HIV pathways to other areas of care, for example, alcohol, drug, youth, maternity and mental health services, can reap benefits particularly in prevention.

DID YOU KNOW?

- in 2013 in England there were 11,062 abortions in women under 18 and 26,330 in those aged 35 and over.⁴¹ Access to effective contraception is needed by women throughout their reproductive years
- in 2013, 37% of women who underwent an abortion had already undergone one or more previous abortions,⁴² up from 31% in 2002⁴³
- in 2010 unintended pregnancies cost the NHS an estimated £193m in direct medical costs⁴⁴
- it has been estimated that £1 invested in contraception saves £11.09 in averted outcomes⁴⁵

Section 6. How to commission across pathways

This section:

- addresses areas of interface and overlap in commissioning of SH, RH & HIV services
- clarifies commissioning responsibility across pathways
- proposes possible solutions to support commissioning of integrated pathways

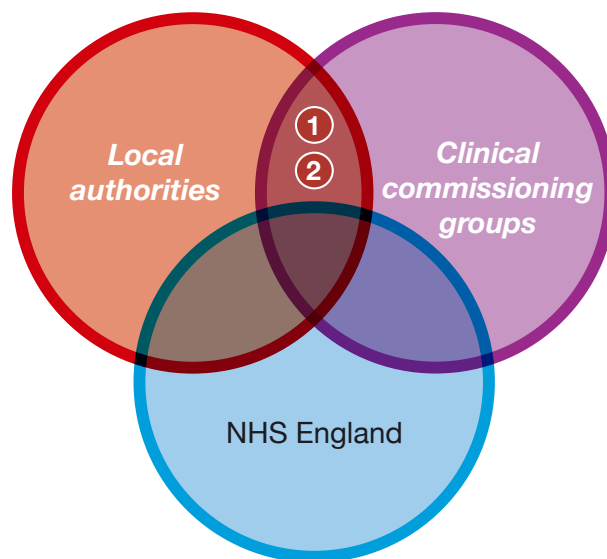
There are a number of areas where commissioning responsibilities interface and overlap in SH, RH & HIV. These areas are highlighted in Figure 10, which clarifies where commissioning responsibility lies across care pathways. Figure 10 also proposes solutions that commissioners can discuss, develop, adopt or adapt locally to support commissioning of integrated pathways.

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

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

For example, 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 – such as 50/50, 60/40 or similar – rather than spending time and resource on working out detailed definitions of the “sexual health” and “non-sexual health” elements of psychosexual services. These arrangements can be reviewed as information on service use develops over time.

Figure 10. Interfaces in commissioning responsibilities and local solutions



Services shared between local authorities and CCGs

① Psychosexual health services

Sexual health aspects of psychosexual counselling (**LAs**)

Non-sexual health elements of psychosexual health services (**CCGs**)

■ LOCAL SOLUTIONS:

Agree the service required.

Design the pathway with referrals from SH, RH & HIV, gynaecology, alcohol, drug and mental health services.

Agree the lead commissioner and commission the service.

Split the cost and agree recharge/invoicing mechanisms.

Monitor service usage and adjust split in costs over time, if required.

Where it is in the best interests of patients, commission from a single provider.

② Integrated abortion care pathway

Pregnancy testing, direct referral and support for self-referral to abortion care from sexual health services (**LAs**)

Abortion care including pre- and post-abortion counselling when needed (**CCGs**)

STI testing and treatment, HIV testing, contraceptive advice and provision as part of abortion care pathway (**CCGs**)

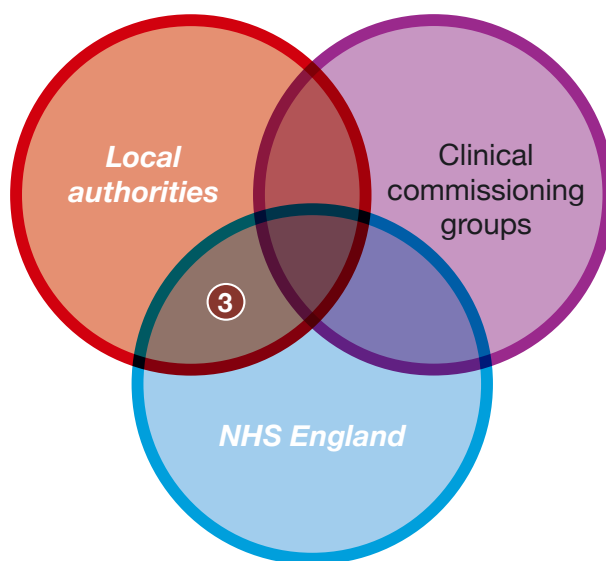
■ LOCAL SOLUTIONS:

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).

Ensure pathways include referral back to sexual health services where contraception, STI or HIV testing requires follow-up.

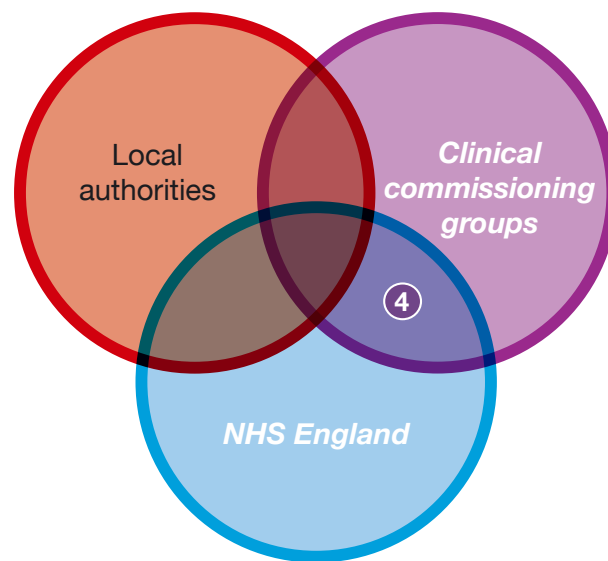
Agree the lead commissioner and commission the integrated pathway/service.

Figure 10. Interfaces in commissioning responsibilities and local solutions



Services shared between local authorities and NHS England
<p>3 Sexual and reproductive health for people living with HIV (PLWH)</p>
<p>Referral to specialist HIV outpatient services following diagnosis (LAs)</p> <p>HIV treatment and 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>Contraception and sexual health advice and provision, including condoms, for PLWH in specialist services and those commissioned from primary care under local public health contracts (LAs)</p> <p>Contraception services for PLWH in general practice under “additional services” in the GP contract (NHS England)</p>
<p>■ LOCAL SOLUTIONS:</p> <p>Commission management of HIV PN as secondary prevention by level 3 GUM/integrated sexual health services, with referral to specialised HIV services of partners diagnosed positive. Consider benefits of service co-location or “nesting” HIV PN within HIV specialised service.</p> <p>Jointly ensure referral pathways are in place to meet the sexual health needs of PLWH including routine STI screening at recommended intervals.</p>

Figure 10. Interfaces in commissioning responsibilities and local solutions



Services shared between NHS England and CCGs

④ Cervical screening^{vii}

Cervical screening activity which is delivered in a variety of settings including SRH and GUM clinics that are commissioned by LAs (*NHS England*)

Cervical screening pathway (*NHS England*)

Cervical screening programme quality assurance (*PHE*)

Investigation/colposcopy following urgent referral due to presence of symptoms (*CCGs*)

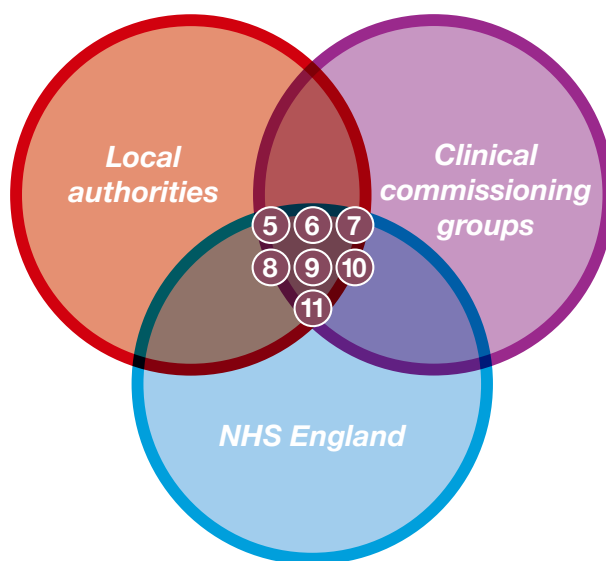
■ LOCAL SOLUTIONS:

Agree local settings for screening programmes; NHS England to update CCGs on location and providers.

NHS England and LAs agree to work together with providers to deliver their respective commissioning responsibilities clinically effectively and efficiently, using recharge mechanisms if appropriate.

vii. Information contained in this section on cervical screening supersedes the information included in the version of this document published on 5 September 2014.

Figure 10. Interfaces in commissioning responsibilities and local solutions



Services shared between all three commissioning bodies
<p>⑤ Support services for people living with HIV (PLWH)^{viii}</p>
<p>Community-based HIV clinical nurse specialists (determined locally)</p> <p>Hospital-based HIV clinical nurse specialists (NHS England)</p> <p>Community-based psychological, social and peer support for PLWH (determined locally)</p> <p>Treatment information for PLWH (determined locally)</p> <p>Psychological support for PLWH as part of routine patient care in general practice (NHS England)</p> <p>Mental health services for PLWH with complex or severe psychological difficulties (CCGs)</p>
<p>■ LOCAL SOLUTIONS:</p> <p>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 for specialised HIV services.</p> <p>CCGs, LAs and NHS England jointly agree commissioning arrangements for psychological and social support and treatment information for PLWH.</p> <p>NHS England, CCGs and LAs jointly agree pathways for PLWH between specialised HIV treatment and care, community-based psychological, social and peer support (including voluntary sector and general practice) and specialist mental health services.</p>

viii. Current commissioning arrangements for community-based support services for people living with HIV are often determined by historical decisions. While some were always commissioned by local government, the budgets for others were transferred in April 2013 from primary care trusts to either CCGs or local authorities. In the case of these services, as with HIV community nurse specialists and the provision of HIV treatment information, there is no centrally determined allocation of commissioning responsibility and arrangements should be locally determined between commissioning bodies to ensure services are provided to meet assessed need.

Figure 10. Interfaces in commissioning responsibilities and local solutions

Services shared between all three commissioning bodies	
6	Maternity pathways
	<p>HIV physicians' referral to and liaison with maternity services for women with HIV (<i>NHS England</i>)</p> <p>Maternity services' management of most complex pregnancies including those of women with HIV (<i>CCGs</i>)</p> <p>Antenatal screening for HIV, syphilis and hepatitis B through NHS Infectious Diseases in Pregnancy Screening Programme (<i>NHS England</i>)</p> <p>Contraception provided for contraceptive purposes in maternity services (<i>CCGs</i>)</p> <p>Post-natal contraceptive advice and provision in general practice or SRH services (<i>NHS England</i>)/<i>LAs</i>)</p>
	<p>■ LOCAL SOLUTIONS:</p> <p>CCGs and NHS England commission services with agreed referral pathways and liaison between HIV outpatient and maternity services for women with HIV.</p> <p>Agree pathways for rapid referral to GUM/integrated sexual health service and/or HIV specialised treatment service for women diagnosed with syphilis, hepatitis B or HIV through antenatal screening.</p> <p>Ensure maternity pathways include referral to general practice or SRH services for postnatal contraceptive care.</p>
7	HIV testing and diagnosis
	<p>In SRH and GUM clinics, and as part of local public health initiatives in any setting (<i>LAs</i>)</p> <p>In antenatal clinics (through the NHS Infectious Diseases in Pregnancy Screening Programme) (<i>NHS England</i>)</p> <p>In general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (ie not part of public health commissioned services but relating to the individual's care) (<i>NHS England</i>)</p> <p>In general practice as part of local public health initiatives, eg offering to new registrants in high prevalence areas (<i>LAs</i>)</p> <p>In "non-traditional settings" – eg community outreach, home sampling (<i>LAs</i>)</p> <p>In termination of pregnancy services (<i>CCGs</i>)</p> <p>In other CCG-commissioned services (including A&E and other hospital departments) as part of patient care (<i>CCGs</i>)</p> <p>In other NHS England-commissioned services as part of patient care (<i>NHS England</i>)</p>
	<p>■ LOCAL SOLUTIONS:</p> <p>Collaborate to ensure expanded HIV testing, in line with national guidance, 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>Jointly monitor potential missed opportunities for diagnosis.</p> <p>Maximise opportunities to ensure those people who test negative remain negative.</p>

Figure 10. Interfaces in commissioning responsibilities and local solutions

Services shared between all three commissioning bodies
<p>8 Post-exposure prophylaxis (PEP) after occupational exposure to HIV and PEP after sexual exposure to HIV (PEPSE)</p>
<p>Initiation and ongoing management of PEPSE in Level 3 GUM clinics (LAs)</p> <p>Initiation of PEPSE in other sexual health services with referral to Level 3 GUM clinics for ongoing management (LAs)</p> <p>Initiation of PEP in occupational health services (CCGs)</p> <p>Outside GUM clinic hours initiation of PEP/PEPSE in A&E departments (CCGs)</p> <p>Antiretroviral drug costs for PEP/PEPSE (NHS England)</p> <p>Health promotion campaigns (LAs)</p>
<p>■ LOCAL SOLUTIONS:</p> <p>Include PEP/PEPSE in specifications for community SRH, GUM and integrated sexual health services, A&E departments and occupational health 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 three commissioning organisations to monitor PEP/PEPSE activity locally, ensuring completion of courses and planning behaviour change interventions as required.</p>
<p>9 Contraception for contraceptive and non-contraceptive purposes</p>
<p>Any contraception for primarily gynaecological (non-contraceptive) purposes, eg intrauterine system (IUS) for heavy menstrual bleeding (CCGs)</p> <p>Contraception for contraceptive purposes in specialist SRH services and those commissioned from primary care under local public health contracts (LAs)</p> <p>Contraception for contraceptive purposes provided as an additional service under the GP contract (GMS, PMS and APMS) (NHS England)</p>
<p>■ LOCAL SOLUTIONS:</p> <p>CCG develops the pathway for contraception for primarily non-contraceptive purposes jointly with the LA as commissioner of 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 community sexual health and gynaecology services.</p> <p>Jointly specify the competence level required to fit the IUS in LA and CCG-commissioned services.</p> <p>Ensure adequate numbers of appropriately trained practitioners to allow all women who require an IUS, for whatever indication, to receive the service.</p>

Figure 10. Interfaces in commissioning responsibilities and local solutions

Services shared between all three commissioning bodies
<p>10 Pathology services as part of SH, RH & HIV services</p> <p>Pathology services associated with STI testing, diagnosis and management provided in sexual health (LAs) and abortion services (CCGs) but excluding areas covered below</p> <p>Pathology services associated with HIV testing (LAs/CCGs/NHS England)</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>
<p>■ LOCAL SOLUTIONS:</p> <p>Agree a common approach to quality standards for diagnostics and laboratory services to ensure consistency across care pathways in SH, RH & HIV services.</p> <p>If tendering, map the pathology services used by providers. Where STI or HIV testing forms a significant percentage of a pathology service's workload, assess the potential risk of destabilisation and the implications for cost of pathology provision for both SH, RH & HIV and wider health services. Advise and involve other commissioners at an early stage.</p> <p>Liaise with other (non-sexual health) commissioners of pathology services to ensure information is shared early about any tendering intentions and the potential impact on local SH, RH & HIV service provision.</p>

Figure 10. Interfaces in commissioning responsibilities and local solutions

Services shared between all three commissioning bodies
<p>⑪ Sexual assault referral centres (SARCs)</p>
<p>Forensic medical examination, sexual health screening, PEPSE and emergency contraception in SARCs <i>(NHS England)</i></p> <p>Services provided to people who have experienced sexual assault attending SRH or GUM services, including referral to a SARC <i>(LAs)</i></p> <p>STI management following referral from SARC to sexual health service <i>(LAs)</i></p> <p>Abortion following sexual assault <i>(CCGs)</i></p> <p>HIV treatment and care following sexual assault <i>(NHS England)</i></p>
<p>■ LOCAL SOLUTIONS:</p> <p>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.</p> <p>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, paediatric, mental health (including child and adolescent mental health) and social services. Address safeguarding issues for children and young people and for vulnerable adults.</p> <p>Jointly document and share clear referral pathways for people who have experienced sexual assault between SARCs and GUM, SRH and abortion services.</p> <p>Specify in LA contracts that integrated sexual health and GUM services should refer to and work with SARCs and provide STI and PEPSE management to patients based on specified referral pathways to and from SARCs.</p>

“It’s fundamental to have a joint understanding of services.”

Figure 11. Commissioning across pathways



The actions required to commission across pathways are summarised in Figure 11.

DID YOU KNOW?

More information is available on cost effectiveness of:

- **LARC** – see the national cost-impact report: ‘Implementing the NICE Clinical Guideline on Long-Acting Reversible Contraception’ (NICE, 2005)⁴⁶
- **HIV screening and testing** – see ‘Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary’ (PHE, 2014)⁴⁷
- **opportunistic chlamydia screening** – see ‘Opportunistic Chlamydia Screening of Young Adults in England: An Evidence Summary’ (PHE, 2014)⁴⁸

See also **leaders’ briefings** on HIV screening and testing⁴⁹ and opportunistic chlamydia screening.⁵⁰

“It’s common sense – ensure you have the same goals and pathways then it will work, even if you have to commission on different time horizons.”

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