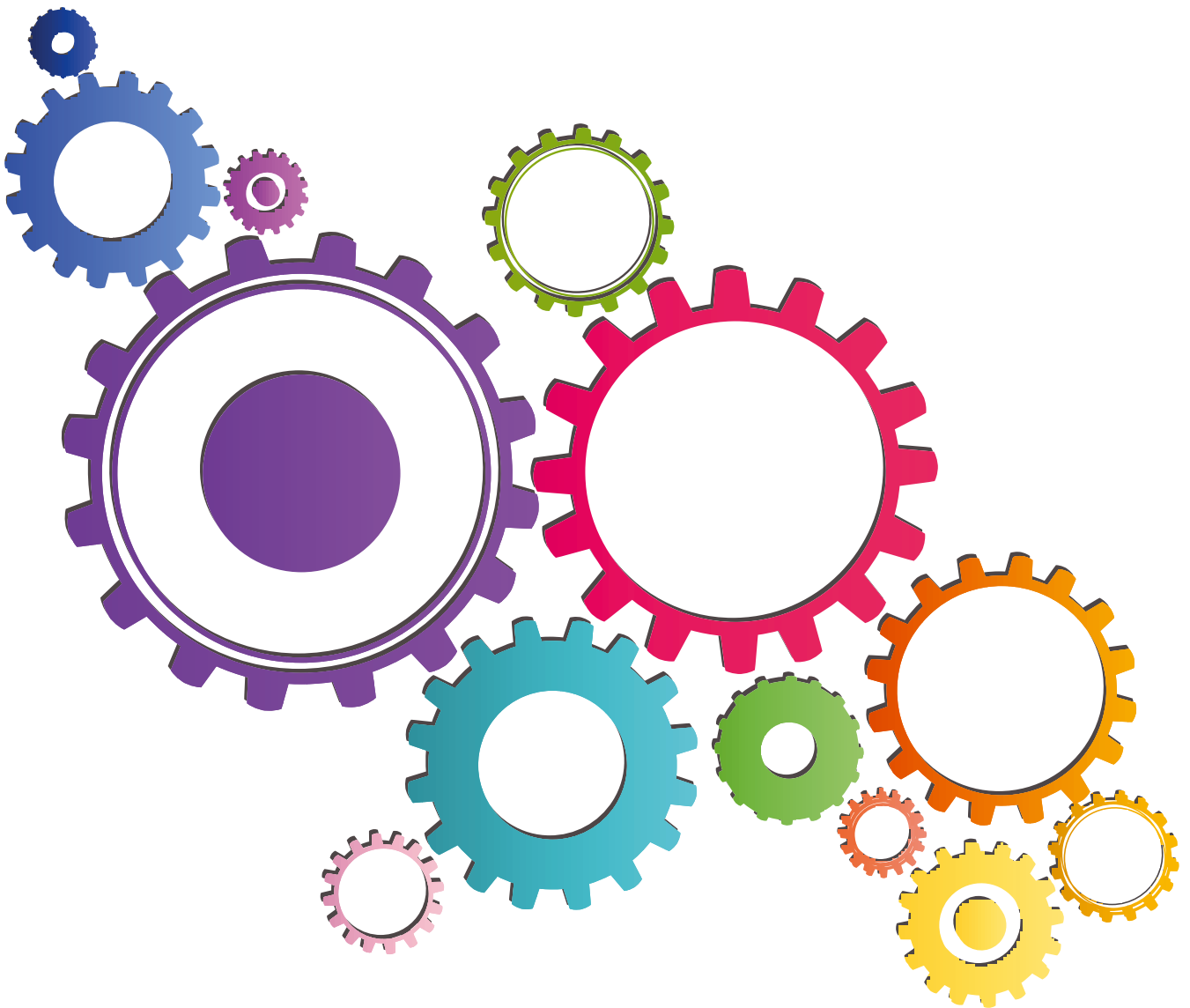




Public Health
England

Making it work

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



September 2014 (revised March 2015)

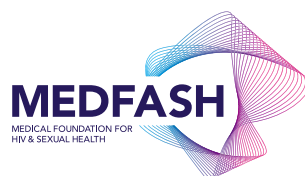


Department
of Health



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.

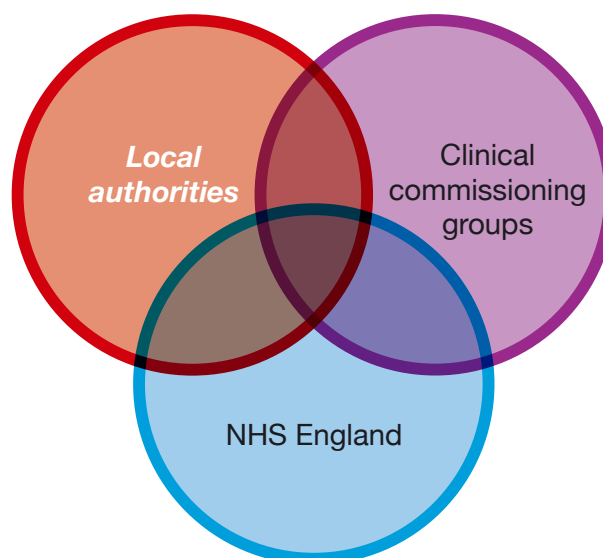
General principles which underpin these arrangements are as follows.

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



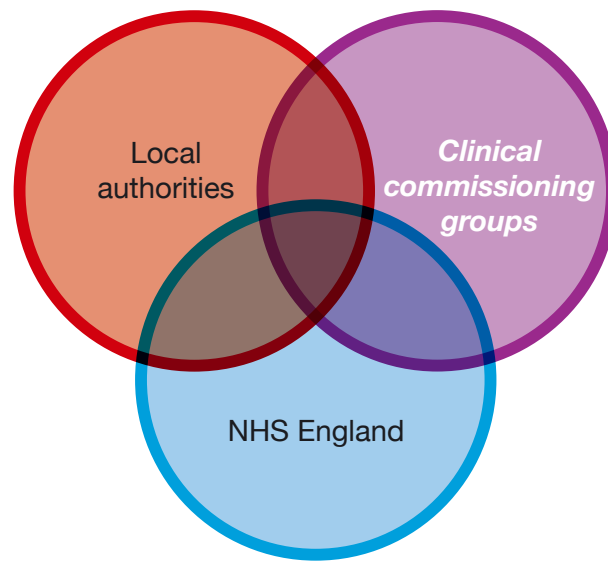
Local authorities commission

- 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

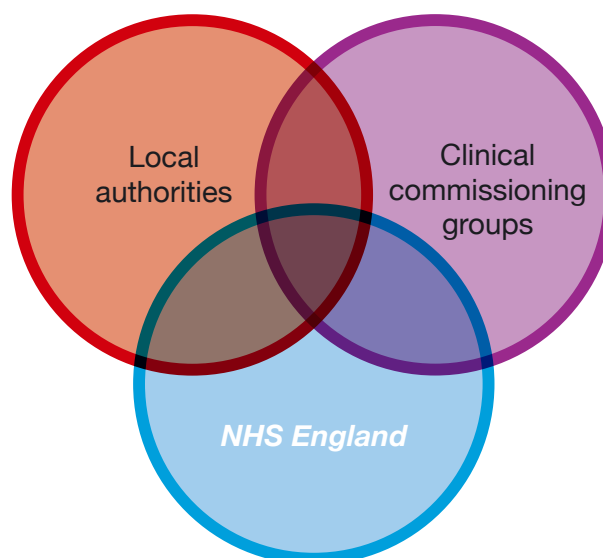


Clinical commissioning groups commission

- 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.

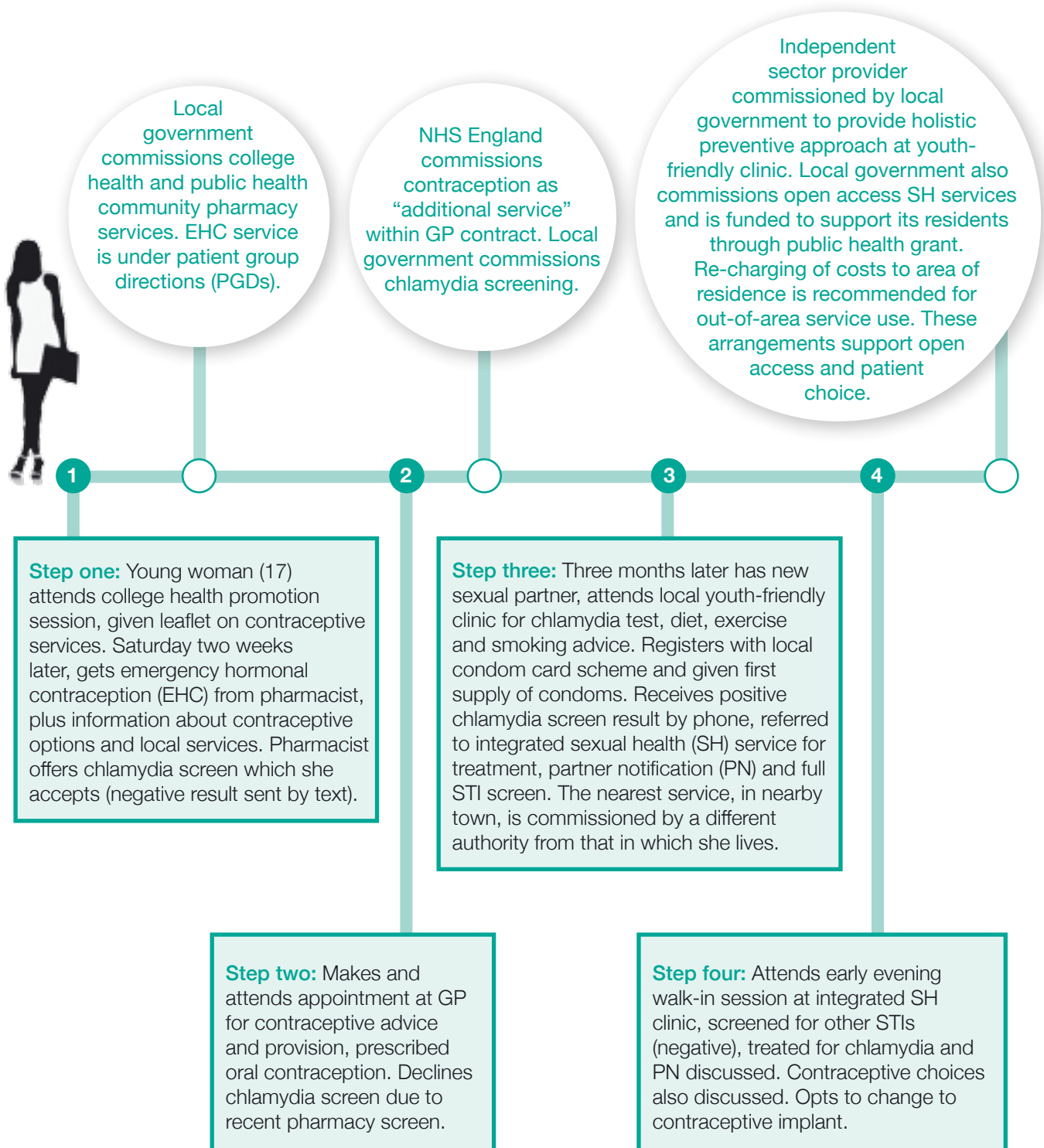
“Whole system commissioning” is an emerging term in health and social care and in developing this guide we offer the following definition which draws on work undertaken in Scotland by the Social Work Inspection Agency.⁷ “A whole system approach to commissioning takes a broad view across the full range 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.

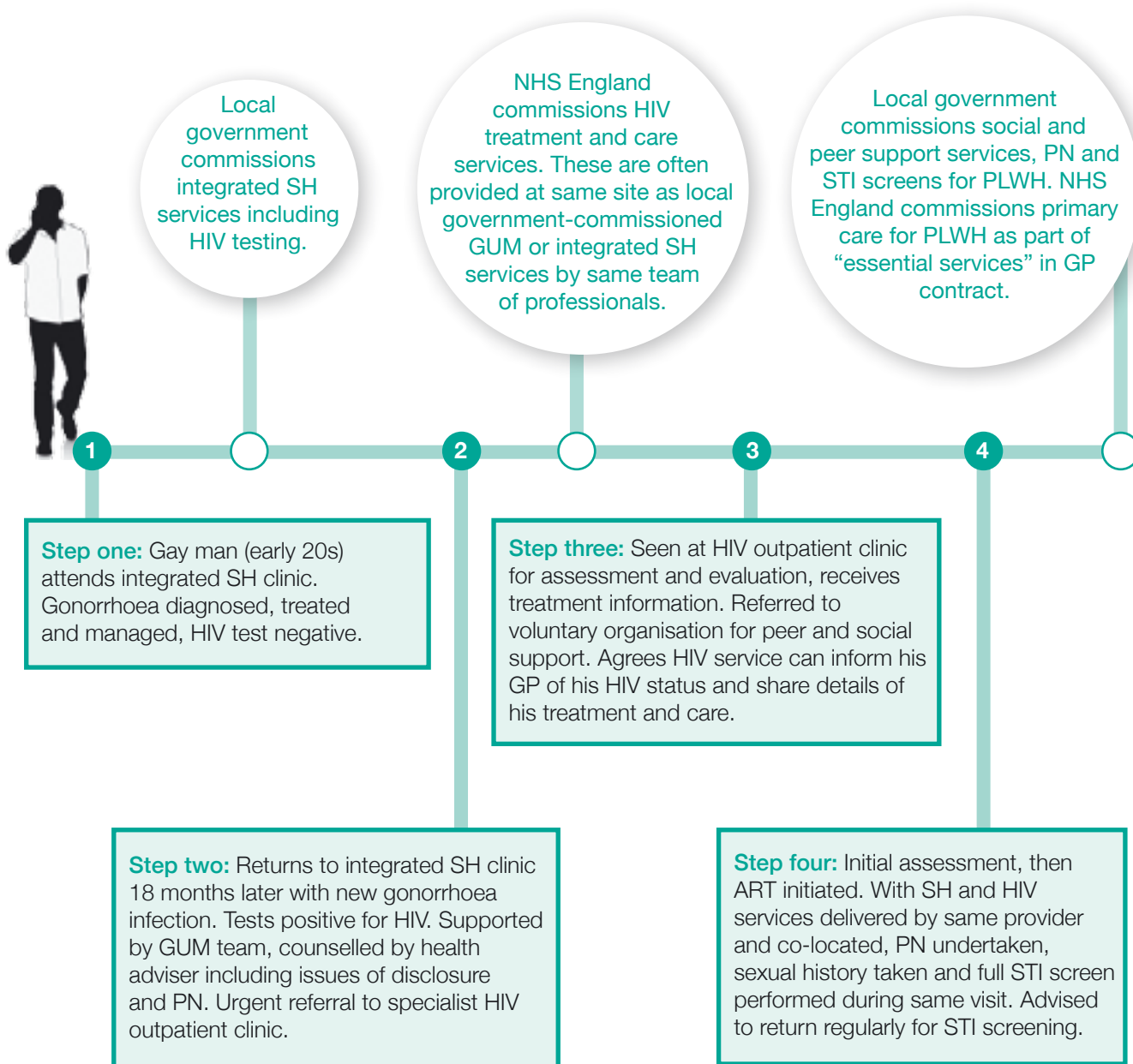
A young woman's journey

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.



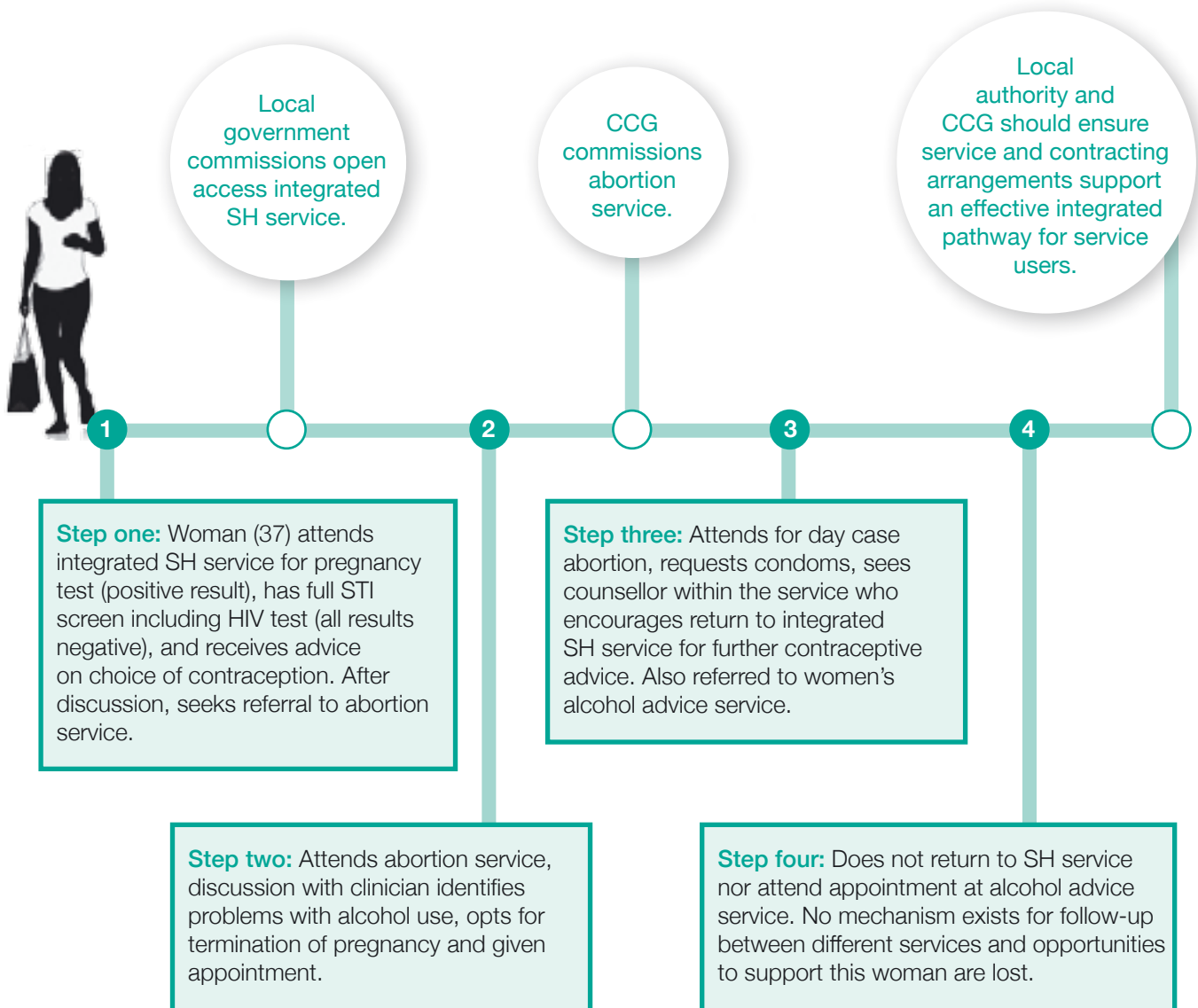
A gay man's journey

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.”

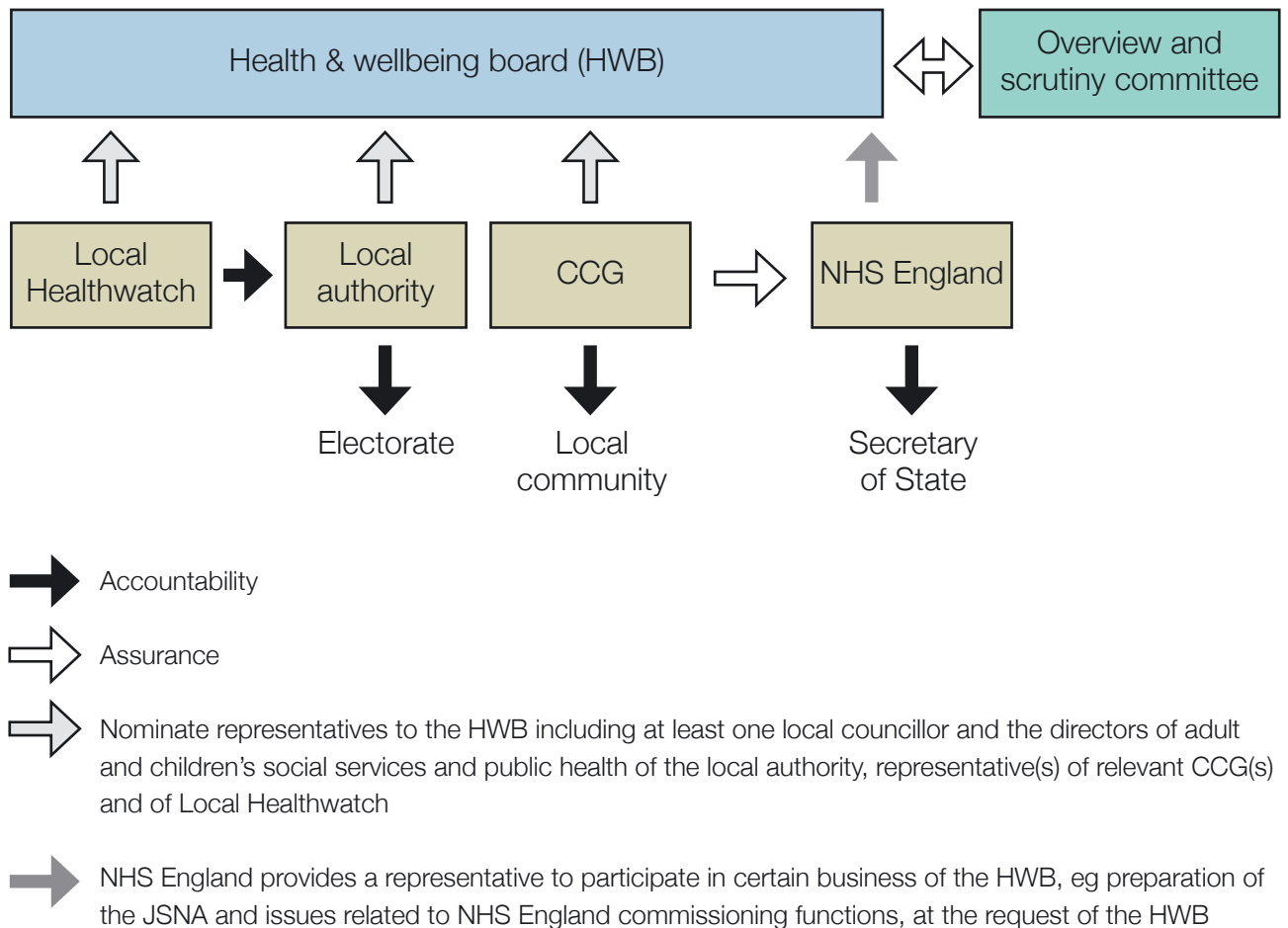
DsPH and their teams also deliver the local authority’s mandated function to advise CCGs on population health which will inform and strengthen their commissioning decisions. Local authorities (and DsPH who would usually act on their behalf) have a critical role in protecting and improving the health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

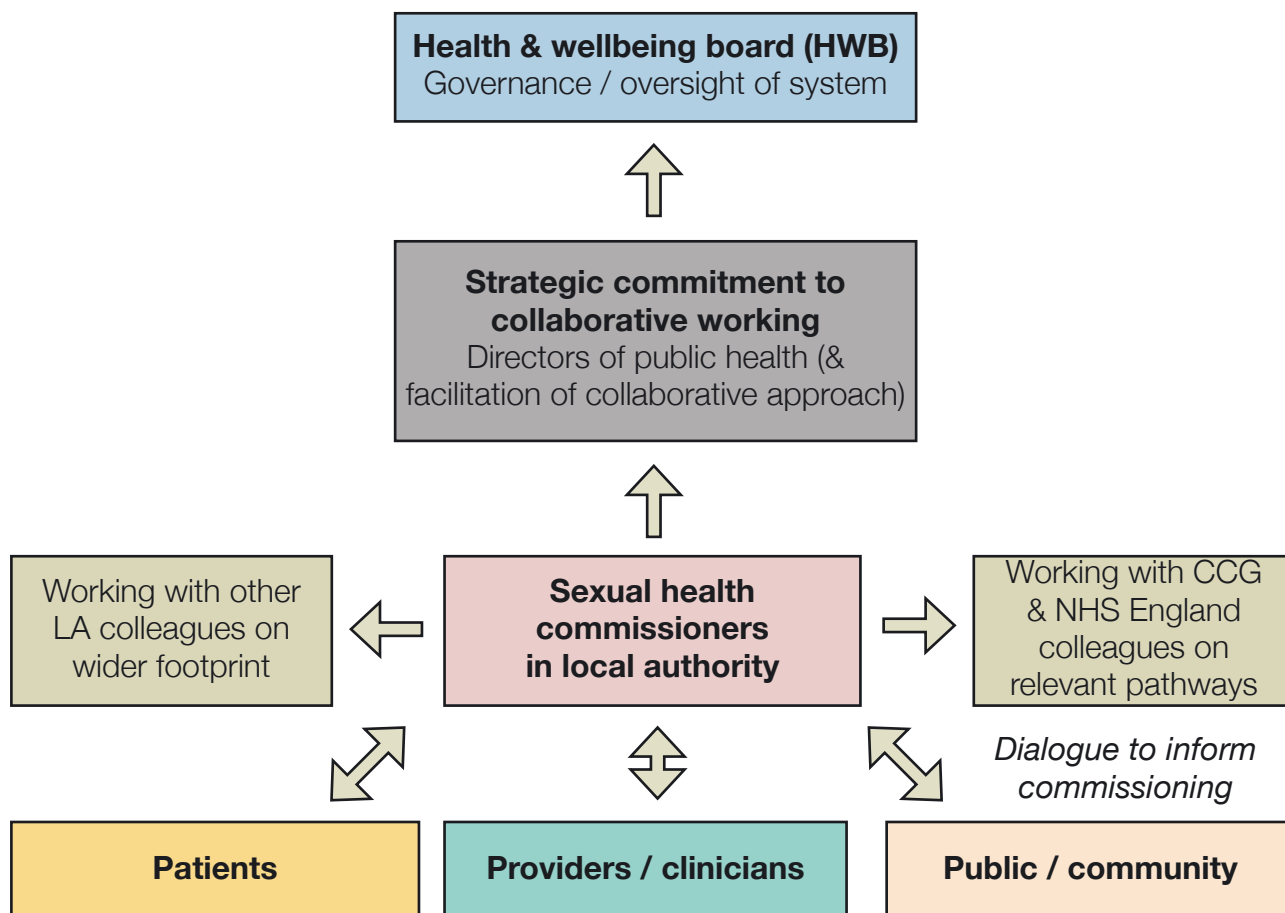
“No-one’s going to come and sort it out for us... It’s down to us.”

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



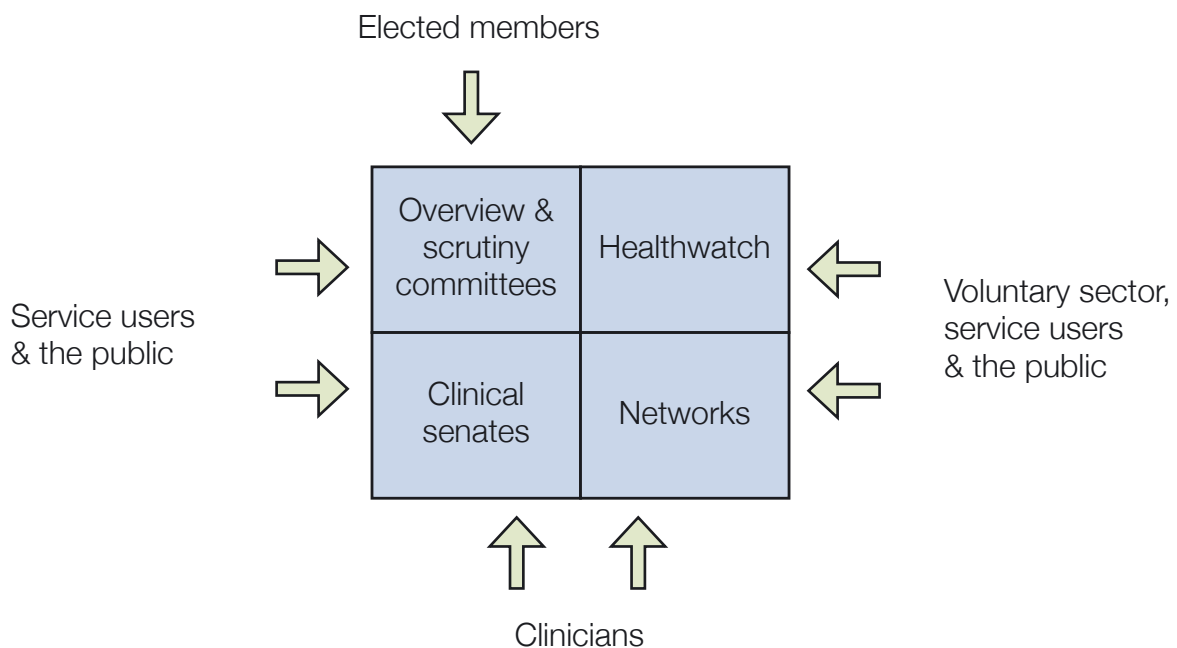
“Involve patients and staff in service redesign and commissioning across the whole system.”

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

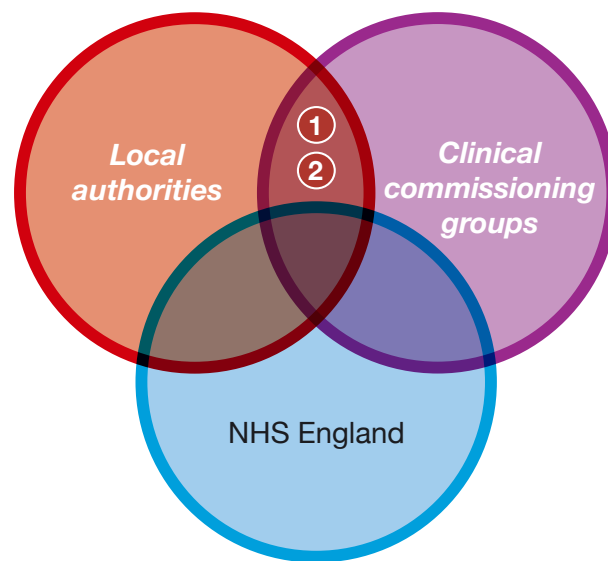
There are a number of areas where commissioning responsibilities interface and overlap in SH, RH & HIV. These areas are highlighted in Figure 10, which clarifies where commissioning responsibility lies across care pathways. Figure 10 also proposes solutions that commissioners can discuss, develop, adopt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

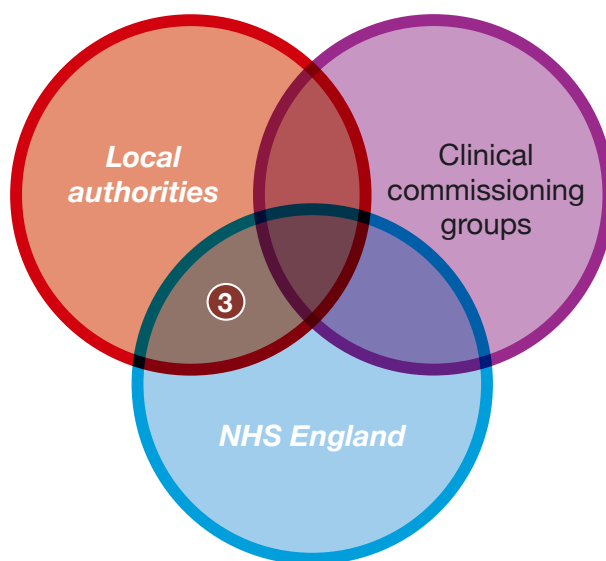
■ LOCAL SOLUTIONS:

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.

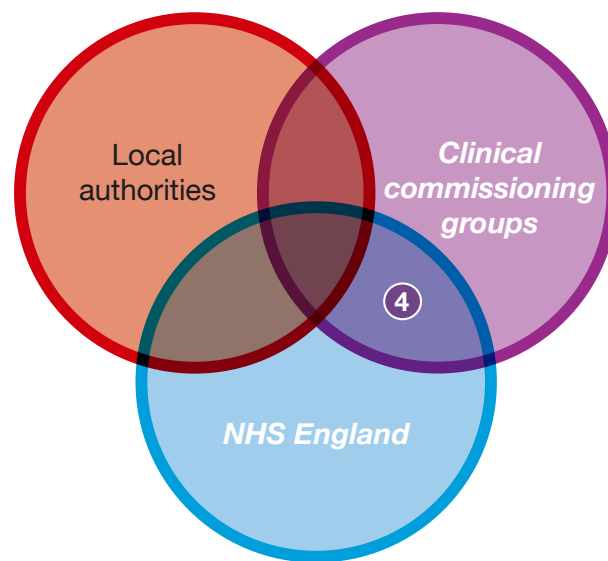
Agree the lead commissioner and commission the integrated pathway/service.

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*)

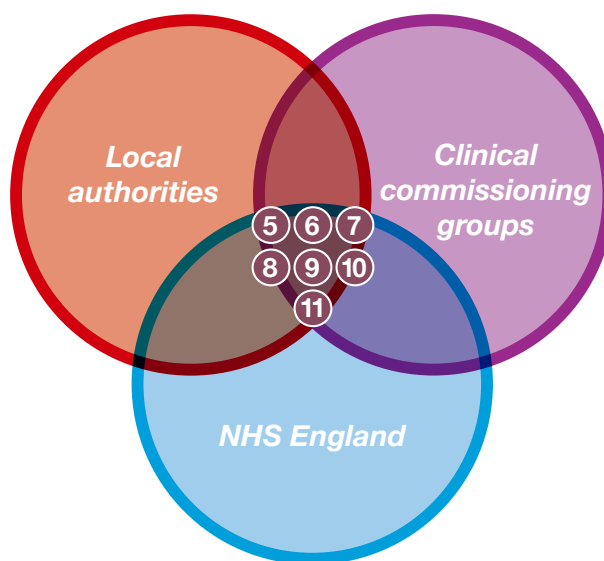
■ LOCAL SOLUTIONS:

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 |
|---|
| ⑤ Support services for people living with HIV (PLWH) ^{viii} |
| <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

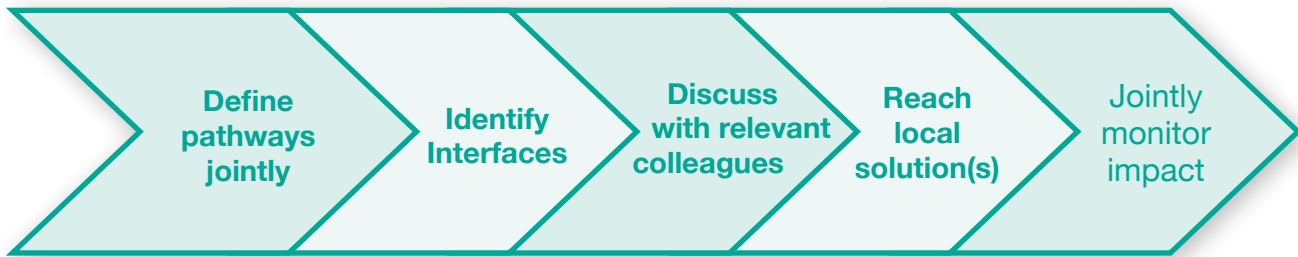
| Services shared between all three commissioning bodies |
|--|
| <p>10 Pathology services as part of SH, RH & HIV services</p> <p>Pathology services associated with STI testing, diagnosis and management provided in sexual health (LAs) and abortion services (CCGs) but excluding areas covered below</p> <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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Case Studies

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

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

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

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

Results

In year one the following has been achieved:

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

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

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

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

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

Results

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

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

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

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

Health in Hackney Scrutiny Commission undertook a scrutiny review focusing on the aim of “controlling the transmission of HIV”. The main driver was the fact that slower progress was being made on HIV than on the other two top sexual health-related priorities which the council is obliged to address in the Public Health Outcomes Framework.

Diagnosed HIV prevalence in the UK is 2 per 1,000 of the population aged 15-59 years. In Hackney it is 7.4 per 1,000, one of the highest in London. Hackney faces increases in new and recent infections (predominantly among MSM) and a problem of late presentation of HIV (predominantly among Black African residents).

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

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

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

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

Results

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

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

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

The following question was addressed: "given the demography of the South West, what would the Senate consider to be the optimal model/s to deliver HIV care to children and adults with specific reference to:

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

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

Results

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

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

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

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

Six local authorities in Berkshire (Slough, Reading, Bracknell Forest, West Berkshire, Royal Borough of Windsor & Maidenhead and Wokingham Borough Councils) established a legal agreement to share resources to commission sexual health services.

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

The key commissioning aims are to ensure equity of access for service users and an efficient use of public health resources. The approach is based on pooling funding, concentrating expertise and developing a county-wide approach. It also facilitates liaison with the commissioners of HIV treatment and care and abortion services. Berkshire has two main sexual health service providers: one hospital-based and one community-based.

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

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

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

Results

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

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

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

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

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

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

The commissioners now use a range of integrated sexual health currencies and tariffs. Each commissioning organisation is responsible for paying for its own activity and either has a contract for the service in place or acts as an associate to a lead CCG or local authority public health contract.

The integrated sexual health service has an overarching service specification and quality outcomes framework. The specification includes cross-references to the national service specification for HIV services held by NHS England. Individual commissioning organisations can edit the overarching specification if required for their own contracts. Abortion services are covered by the integrated services specification. HIV treatment and care is commissioned by the NHS England specialised services commissioning area team. Contract and performance management by the local authorities and CCGs is undertaken collaboratively with support from integrated CCG & local authority commissioning units, where these exist, and the local commissioning support unit. Commissioners hold a joint pre-meeting prior to quarterly service review meetings.

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

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

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

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

The Wigan health and wellbeing board promotes integrated working. This helped to create a seamless transition to the new commissioning arrangements. Wigan Borough's ambition is to design integrated sexual health services around the service user.

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

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

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

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

Results

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

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

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

Significant savings to the CCG have been realised since the collaborative commissioning arrangements began, with improvements in treatment under 10 weeks, non-attendance rates and uptake of LARC .

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

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

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

The following benefits of collaboration were identified:

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

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

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

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

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

Results

The collaborative approach with performance and quality indicators included in the common service specifications has led to a more consistent approach to service delivery and streamlined the commissioning process. In addition, the approach will aid discussion on implementation of the integrated sexual and reproductive health tariff.

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

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

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

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

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

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

- a. identify a named point of contact for HIV specialised commissioning in the AT (specialised commissioning hub) and ensure they had made contact with the leads for sexual health commissioning in the relevant local authorities
- b. identify any activity or contracts not yet transferred to NHS England
- c. identify the currency and pricing arrangements of existing contracts and the elements of service covered. This will support the forthcoming pricing work on the national HIV outpatient tariff
- d. identify and act on any immediate risks to HIV service provision to ensure there is no deterioration in service
- e. ensure NHS England involvement in any sexual health tendering process, especially where current provision is integrated GUM and HIV
- f. promote patient and public engagement in any changes to provider configurations

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

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

Results

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

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

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

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

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

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

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

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

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

Results

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

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

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

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

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

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

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

Results

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

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

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

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

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

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

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

- a health and wellbeing service (part delivered by council employees and part through an NHS health improvement partnership arrangement) providing teacher training on sex and relationships education (SRE) and drugs and alcohol health promotion in targeted schools. This includes promoting awareness about sexual assault through sessions delivered by the SARC healthcare professionals
- sexual health service staff promoting breastfeeding and midwives having a pathway of referral to the sexual health service. The contract includes targeted work with teenage mothers, aiming to increase contraception uptake by taking services such as LARC provision to clients in their homes. This includes implant insertion, injectable methods, condom promotion, and holistic health information and guidance on breastfeeding and alcohol consumption
- the targeted adolescence team and Sure Start Children's Centres providing brief health promotion interventions on risk-taking behaviours including drugs and alcohol, offering chlamydia screening and signposting to emergency contraception at pharmacies, sexual health services and LARC methods

- the school health service delivering universal SRE in Year 5 and Year 8 and signposting to the community sexual health sessions delivered weekly in 13 secondary schools. They offer a range of contraceptive methods, asymptomatic screening for STIs and referrals to additional services such as termination, pregnancy support and advice

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

Results

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

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

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

The director of public health chairs the steering group which is co-ordinated by a member of the public health commissioning team. Membership of the group is broad including local authority children's commissioners and service leads, sexual health services, midwifery, health visiting, academies, colleges and voluntary sector organisations. A number of organisations, including the CCG and NHS England area team, are part of the wider professional stakeholder network.

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

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

Results

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

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

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

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

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

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Case study 14. “Positive Steps into Work” – working across local government to support people living with HIV to find employment

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

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

The service is built on the premise that employment support is a specialist skills set and is therefore best provided by those able to give good quality information, advice and guidance with understanding of the local labour market, rather than being an add-on to the role of “key workers” in health-related agencies. In this way, support to enter or return to employment or training is tackled independently from clients’ other support needs. This allows workers to focus solely on the client’s barriers to employment without becoming enmeshed in other areas of their lives.

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

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

Results

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

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

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

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

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

The group also:

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

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

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

Results

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

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

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

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Annexes

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

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

The legislation facilitating a whole system commissioning approach is the NHS Act 2006ⁱ and the Health and Social Care Act 2012ⁱⁱ. The key sections of the Acts promoting integration and encouraging integrated working are highlighted below. Both are enshrined as duties in the Health and Social Care Act 2012. The Act further imposes a duty on NHS bodies and local authorities to co-operate with one another in exercising their respective functions. The Department of Health underlines the duty to co-operate in its circular to local authorities on the ringfenced public health grant (LAC(DH)(2013)1 10 January 2013) thus:

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

Duty to promote integration

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

The Board must exercise its function with a view to securing that health services are provided in an integrated way where it considers that this would:

- (a) improve the quality of those services (including the outcomes that are achieved from their provision)
- (b) reduce inequalities between persons with respect to their ability to access those services
- (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

Section 14Z(1) of the 2006 Act, as amended, outlines the “Duty as to promoting integration” for CCGs. The terms of the duty are identical to those outlined above for NHS England.

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Duty to encourage integrated working

Joint health and wellbeing strategies

Section 193 of the Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007, to introduce duties on local authorities, CCGs and NHS England. (See new sections 116A and 116B of the Local Government and Public Involvement in Health Act.)

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

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

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

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

Section 195 of the Health and Social Care Act 2012 imposes a duty on HWBs to encourage integrated working.

Section 75 of the NHS Act 2006

Section 75 of the NHS Act 2006 governs arrangements between NHS bodies and local authorities. It sets out a regulation-making power to prescribe arrangements which may be entered into, functions to which those arrangements may relate, and the NHS bodies and local authorities which may enter into them. The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617) are deemed to be made under section 75. They list local authority public health functions under the NHS Act 2006 and CCG commissioning functions under that Act as functions which may be the subject of partnership arrangements where the arrangements are likely to lead to an improvement in the way those functions are carried out.

Further details are outlined in Annex B of ‘Sexual Health Clinical Governance: Key Principles to Assist Service Commissioners and Providers to Operate Clinical Governance Systems In Sexual Health Services’ (DH 2013) – see Annex 1. A partnership arrangement between a local authority and a CCG under section 75 is one option to fulfil the duty for integrated working. Subject to the statutory requirements in the 2000 Regulations mentioned above, this can include the two bodies contributing to a fund (a “pooled budget”) to commission services collaboratively. NHS England’s area teams can also participate in collaborative commissioning subject to authorisation of the section 75 arrangement by the relevant Regional office.^{iv} An example of how Luton Borough Council and Luton CCG have used this mechanism to provide integrated services for children with additional needs is given below. Further options exist to facilitate collaboration between local authorities, CCGs and NHS England. These include collaboration without pooled budgets and jointly agreed service specifications and are outlined in Sections 4 and 5 of this guide.

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

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

A joint management team oversees both the service and the partnership arrangements. The partners both contribute revenue to the service, within agreed budget planning and financial management processes. These include the timetable and deadlines for financial planning, regular financial management reports and mechanisms for dealing with overspends or underspends. The agreement has clauses covering review, termination, variation, dispute and resolution, complaints, statutory obligations and governing law.

The agreement’s schedules cover the following:

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

iv. Public Health England; Department of Health; Local Government Association; NHS England; Association of Directors of Public Health. HIV, sexual and reproductive health current issues bulletin: issue 3, Commissioning HIV services. February 2014; www.gov.uk/government/publications/hiv-sexual-and-reproductive-health-current-issues-bulletin-issue-3-february-2014 Accessed on: 04/07/2014

- **financial arrangements** including finance flows, financial planning and budget setting process, budget performance and access to financial information
- **governance and performance reporting** through a joint management group chaired by a senior officer of the council. The group has responsibility for the annual commissioning and financial plan, risk management, outcomes, systems for client feedback and a report to both executives. Performance reporting uses national and local indicators, updates on service development plans and reports on action plans arising from service and regulatory inspection
- **services in the agreement**, including strategic objectives, legislative context and a description of the joint commissioning team and integrated children's and young people's services. The aim of the integrated service is to provide a co-ordinated and accessible service with a single point of referral, information, assessment and delivery of support for disabled children and their families. The objective of the service is that children and young people with disabilities and/or a life-limiting condition will be able to easily access the support of their choice from a flexible, responsive and coherent network of high quality services, allowing them and their families to lead lives that are as normal as possible

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

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

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

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

A Framework for Sexual Health Improvement in England

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

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

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

Commissioning Sexual Health Services and Interventions: Best Practice For Local Authorities

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

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

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

The NHS Outcomes Framework

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

- provides a national overview of how well the NHS is performing
- is the primary accountability mechanism, in conjunction with the Mandate, between the Secretary of State for Health and NHS England
- drives up quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process

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

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

The Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) for 2013-16 includes three SH, RH & HIV indicators. They are as follows:

- under 18 conceptions
- people presenting with HIV at a late stage of infection
- chlamydia diagnoses (15–24 year olds)

A number of other indicators in the PHOF are also relevant for SH, RH & HIV. Examples include violent crime including sexual violence, take-up of the NHS health check programme, and low birthweight of term babies.

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

These provide details of the requirements each local authority needs to have in place for the provision of open access sexual health services, including contraceptive services, for the benefit of all people present in its area, specifically:

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

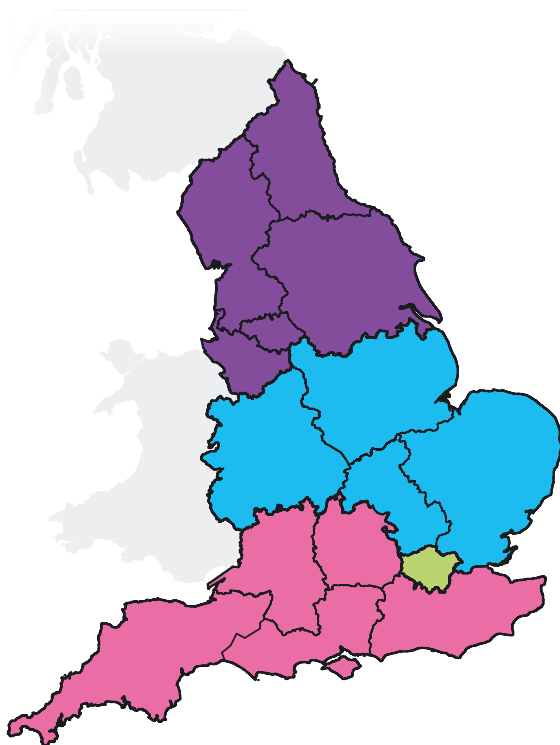
The regulations do not set out how the services should be provided, nor impose any requirements on the numbers of services, locations, opening times, type of service model, waiting times or staffing levels. These will be determined locally and will make a difference to the quality of services and to the achievement against the Public Health Outcomes Framework (PHOF) and the objectives of 'A Framework for Sexual Health Improvement in England'.


Annex 4. NHS England arrangements for directly commissioned services

NHS England directly commissions:

- specialised services
- primary care services
- health and justice services
- services for members of the armed forces

NHS England has 4 regions and 27 area teams but acts as a single organisation with one board and a single operating model for commissioning.



- | | |
|---|------------------------------|
|  | North of England |
|  | Midlands and East of England |
|  | London |
|  | South of England |

Commissioning of public health services is carried out by Public Health England (PHE) and local authorities, although NHS England commissions, on behalf of PHE, many of the public health services delivered by the NHS.

NHS England commissions many of the primary care services previously commissioned by PCTs. It is responsible for primary care contracts and has a duty to commission primary care services in ways that improve quality, reduce inequalities, promote patient involvement and promote more integrated care. NHS England is a single organisation and takes a consistent approach to managing contracts wherever it is appropriate to do so.

NHS England is also responsible for primary care support services (also known as family health services).

NHS England works with other bodies, including the Department of Health, PHE, CCGs, the NHS and local government, to develop commissioning models for public health commissioning.

The public health services NHS England commissions directly are:

- national immunisation programmes
- national screening programmes
- public health services in the justice system
- sexual assault referral centres (SARCs)
- public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme)
- child health information systems

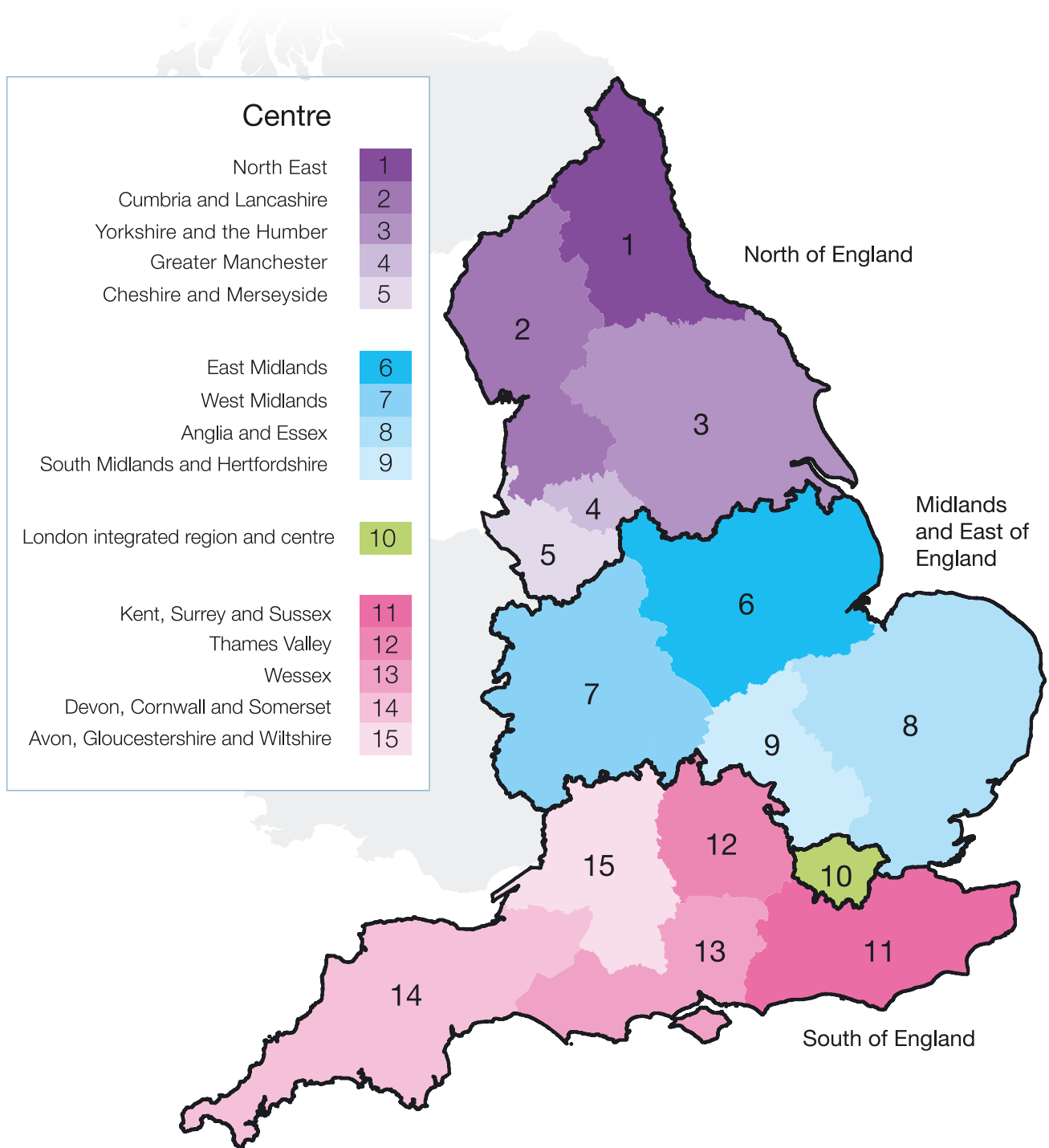
Ten area team hubs lead on **specialised services commissioning (in bold below)** including HIV treatment and care for adults and children and specialist fetal medicine services.

Ten area teams lead on ***health and justice services (in bold italics below)*** including sexual health elements of healthcare in secure and detained settings and SARCs.

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

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

Annex 5. Public Health England: regions and centres



Annex 6. Managing outbreaks of sexually transmitted infections

A Lymphogranuloma venereum (LGV) outbreak in urban centres: lessons for commissioners

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

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

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

If there is evidence the outbreak is spreading beyond local and regional boundaries, a national OCT is established to enable a standardised and co-ordinated response. This happened for the LGV outbreak. Control measures included expanded testing, treatment and partner notification, as well as strategies for raising awareness in the local populations and among health professionals. The promotion of safer sex through the use of condoms, leaflet campaigns and targeted press releases, was also employed in collaboration with Terrence Higgins Trust.

Results

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

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

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Annex 7. Glossary of abbreviations

| | | | |
|---------------|---|----------------|---|
| ACRA | Advisory Committee on Resource Allocation | LGBT | Lesbian, gay, bisexual and transgender |
| APMS | Alternative Provider Medical Services | LSOA | Lower super output area |
| ART | Antiretroviral therapy | MEDFASH | Medical Foundation for HIV & Sexual Health |
| ARV | Antiretroviral | MSM | Men who have sex with men |
| AT | Area team | NAT | National AIDS Trust |
| BASHH | British Association for Sexual Health and HIV | NCSP | National Chlamydia Screening Programme |
| BHIVA | British HIV Association | NES | National Enhanced Service |
| BPAS | British Pregnancy Advisory Service | NICE | National Institute for Health and Care Excellence |
| CCG | Clinical commissioning group | NIHR | National Institute for Health Research |
| CLAHRC | Collaborations for Leadership in Applied Health Research and Care | OCT | Outbreak control team |
| CRG | Clinical Reference Group | PCT | Primary care trust |
| CSRH | Community sexual and reproductive health | PEP | Post-exposure prophylaxis |
| DH | Department of Health | PEPSE | Post-exposure prophylaxis following sexual exposure |
| DPH | Director of public health | PGD | Patient group direction |
| DsPH | Directors of public health | PHE | Public Health England |
| EHC | Emergency hormonal contraception | PHOF | Public Health Outcomes Framework |
| ESHHCG | English Sexual Health and HIV Commissioners Group | PLWH | People living with HIV |
| FSRH | Faculty of Sexual and Reproductive Healthcare | PMS | Personal Medical Services |
| GMS | General Medical Services | PN | Partner notification |
| GUM | Genitourinary medicine | PSHE | Personal, social, health and economic (education) |
| HIV | Human immunodeficiency virus | RH | Reproductive Health |
| HWB | Health and wellbeing board | SARC | Sexual assault referral centre |
| IUCD | Intrauterine contraceptive device | SH | Sexual health |
| IUD | Intrauterine device | SHLC | Sexual Health Lead Commissioner |
| IUS | Intrauterine system | SRE | Sex and relationships education |
| JHWS | Joint health and wellbeing strategy | SRH | Sexual and reproductive health |
| JSNA | Joint strategic needs assessment | STI | Sexually transmitted infection |
| LA | Local authority | TasP | Treatment as prevention |
| LARC | Long-acting reversible contraception | TUPE | Transfer of Undertakings (Protection of Employment) |
| LES | Locally enhanced service | | |
| LETB | Local education and training board | | |

Annex 8. Acknowledgements

The NHS England Public Health Steering Group charged PHE with developing this guide on behalf of PHE, NHS England, LGA, ADPH and Department of Health.

The development of the commissioning guide was overseen by a Steering Group which reported to the PHE Priority Programme Board for Sexual Health, Reproductive Health and HIV, with input from an expert Advisory Group. The membership of both groups is given on page 110. Thanks are due to all members of the two groups.

The development of this guide was informed by a review of documentation, a series of interviews and two stakeholder workshops. Thanks are due to the interviewees, workshop participants and case study owners, named in the guide, who shared their emergent local practice and experience, and to all those who submitted comments on the final draft.

In developing this guide a number of issues were raised that fell outside the remit of the document, but are nonetheless important issues that need further consideration. To address this, an issues log was developed that will be considered by Public Health England and the NHS England Public Health Steering Group.

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|--------------------------------------|---|
| Kate Folkard | Public Health England, Chair |
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| Derek Bray | NHS England |
| Andrea Duncan | Department of Health |
| Claire Foreman | NHS England |
| Judith Hind | Department of Health |
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| David Regan | Association of Directors of Public Health |
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| Advisory Group membership | |
|----------------------------------|--|
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| Anthony Chuter | Patient and public engagement representative |
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| Melanie Savage | Stafford and Surrounds CCG & Cannock Chase CCG |
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