

Collaboration and cooperation

Sexual and reproductive
health commissioning
in local government

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Foreword

Sexual health is an important part of people's lives and the consequences of poor sexual health can be serious. So it is worrying that Public Health England reports a 5 per cent increase from 2017 to 2018 in STI diagnoses in England, reaching a total of 447,694.

For working aged adults, access to contraception remains important and needs to be universally accessible. It is concerning that whilst over the last 10 years, abortion rates have been decreasing for women under 25, they have been increasing for women aged 30 and over.

It is also a fact that poorer sexual health is not evenly distributed across the population. Those living in poverty, socially excluded, young people under 25 and men who have sex with men are all at higher risk.

Many different factors can influence sexual health, relationships and safer sex, from personal attitudes and peer pressure to emotional resilience, confidence, self-esteem, substance misuse and exploitation.

Into this complex picture step commissioners. Responsibility for services is split between local government, clinical commissioning groups (CCGs) and NHS England.

Councils are in charge of sexually transmitted infection (STI) testing and treatment, contraception, psychosexual counselling and advice on preventing unintended pregnancy. They are also responsible for sexual health promotion, including HIV prevention and services in schools and colleges.

However, HIV treatment and care, including the cost of all antiretroviral treatment, services for prisoners and cervical screening falls under the umbrella of NHS England, as do basic contraception services provided under the GP contract.

Meanwhile, CCGs take the lead on abortion services, female sterilisation, vasectomy and HIV testing in commissioned settings such as hospitals.

These arrangements have been in place since 2013 when responsibility for public health was transferred to local government as part of the wider reorganisation of the NHS.

Fragmentation was a feature of the system long before the transfer of services in 2013. This was pointed out by a number of reports and it has probably become more visible over recent years. The fragmented nature of the system, coupled with the cuts to the public health grant, has created challenges.

Service users, of course, do not think of sexual health in terms of who commissions it and why. They expect to have accessible, confidential and integrated services so councils have had to work hard to maintain these and build on them in this commissioning landscape.

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 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.

A whole system approach needs to be taken at both the local and national levels, covering prevention, improvement, promotion and protection, and spanning the three areas of sexual health, HIV and reproductive health including contraception. Attempts to tackle these issues in isolation will lead to silo working and will not be representative of people's experiences of sexual health, which are not divided into the three categories.

The economic climate and pressure on resources are encouraging everyone to explore new approaches and opportunities that can deliver better outcomes and better value.

There are examples included in this report of councils that have led the way through the creation of strong commissioning networks and expert groups. Contract tenders have been coordinated and best practice shared, ensuring those who need it have access to seamless and coordinated services.

Other areas have used the opportunity of being in local government to work proactively with different parts of the system. In Buckinghamshire this has included a focus on child sexual exploitation. There are also examples of services that are working alongside drug and alcohol services to provide more coordinated care for vulnerable groups.

Councils, working with their partners, have also been at the forefront of the digital revolution in sexual health services. With the public increasingly using online services to do everything from shopping to banking, it is only right that people can get advice and access testing online.

Six years on from getting responsibility for some sexual health services, councils are well on the way to shaping a modern, responsive and proactive service to meet the needs of all.

A handwritten signature in black ink, appearing to read 'Ian Hudspeth', with a long horizontal flourish underneath.

Councillor Ian Hudspeth
Chairman
LGA Community Wellbeing Board

Blackpool Council: the benefits of sharing good practice

Blackpool Council has worked with neighbouring areas to share good practice when it comes to sexual health services. It has helped the council improve and develop the way it provides support.

The challenge

Blackpool is one of the most deprived areas of the country with historically high rates of teenage conception and abortion rates.

Overall the trend for STI diagnoses is down, although rates still remain at concerning levels. The re-infection rate is also high, significantly so for young people.

In developing sexual health services, Blackpool has recognised the benefits of working with other councils in the region and sharing good practice.

The solution

Regionally Lancashire and Cumbria have a sexual health commissioners network – and this has provided the foundations for collaborative working.

There was a joint procurement exercise for STI testing and contraception services in 2014. This involved a shared market engagement process, although each council was able to make its own decision on which provider to award contracts to.

Public Health Specialist Judith Mills said, “this exercise was important to do as many of the councils shared the same providers and residents cross borders to access services. There was a potential for providers to be destabilised by a series of individual procurement process taking place.”

Since then there has been a number of sector-led improvement workshops with neighbouring councils and Public Health England to look at what has worked across the different providers.

Ms Mills said: “The approach has allowed us to really share good practice and learn from each other. Performance – whether it is on chlamydia screening or long-acting reversible contraception (LARC) can vary enormously.

“We have built up a good idea of what works and have started introducing new measures to improve the service we provide to people.”

The impact

Over the past 18 months, a series of new initiatives has been launched. These include a domiciliary care pathway to ensure vulnerable women have access to LARC. It is aimed at those engaged with services such as mental health, substance misuse and learning disabilities and involves their key worker and a sexual health practitioner carrying out home visits to arrange LARC.

This scheme has worked in partnership with Blackpool's Pause Project, which is part of a national movement to provide support to women who are at risk of having their children taken into care.

Other collaborations have also been developed. These include sexual health workers and harm reduction staff working together to support sex workers and the co-location of sexual health and substance misuse workers so people can be offered help with drug and alcohol addiction alongside STI testing and contraception services.

Lessons learned

Introducing new initiatives nearly always requires some kind of evolution and adaptation.

Ms Mills said: "Take the co-location of substance misuse and sexual health for example. When we first launched it, we did not have much success. Clients were not coming forward for testing.

"What we realised was that they need to be stable in their drug and alcohol treatment before they were ready for other help. So we now offer the sexual health services later on.

"It is proving much more effective – with lots more people getting tested."

How is the approach being sustained?

New initiatives are being looked at all the time. HIV testing started to be offered to all patients aged 16 to 70 who were in the acute medical unit at the Blackpool Victoria Hospital last year. The success of that led Blackpool to start testing for Hepatitis C recently.

Blackpool also wants to make progress with offering self-testing at home. In 2018 access to full screen online postal kits was launched with the uptake of this offer growing and the average return rate of 50 per cent.

The service is also busy preparing for statutory relationship and sex education from 2020. A coordinator has been appointed to liaise with schools and partner agencies, such as school nursing, mental health and tobacco control.

"There is a lot we want to build on. Through our work with others in the region we are always finding out about new ways to deliver services," Ms Mills added.

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Buckinghamshire County Council: playing a key role in child sexual exploitation

The public health team at Buckinghamshire County Council has worked with multiple partners to help tackle child sexual exploitation (CSE). It has involved training for staff and a project with community pharmacists to help them spot those at risk when they come in for emergency hormonal contraception (EHC).

The challenge

There has been growing awareness about the risks of CSE in recent years following a number of high profile cases. It has become clear that CSE can be experienced in all communities.

As a result, Buckinghamshire's Children's Safeguarding Board has made the issue a top priority.

The board has committed to do all it can to prevent it happening, protect those at risk and pursue those responsible as part of its 'CSE Promise'.

The solution

An exploitation sub-committee exists to oversee this work and includes a range of different partners, including the sexual health public health lead.

Public Health Principal Angie Blackmore said: "One of the real benefits of being in local government is to really develop the opportunity to work with different partners – education, youth and community, social care, police and the voluntary sector – CSE is the perfect illustration of that.

"We knew our sexual health services could have a role in tackling this and so we have tried to play our part."

One of the first steps taken in 2014 was the introduction of training on for those working in specialist sexual health services to help them identify those at risk of CSE.

Workshops using the national British Association for Sexual Health and HIV and Brook Spotting the Signs screening tool were organised. Around 140 participants have taken part to date, as well as attending Buckinghamshire safeguarding training to understand local policies and procedures.

Ms Blackmore has also worked with community pharmacists over their dispensing of EHC.

EHC requests are monitored to look for unusual patterns of attendance with community pharmacies using a registration system to help them recognise when unusual patterns emerge and then report cases.

Ms Blackmore worked with a specialist CSE social worker in the Swan Unit – a unit initially set up across the police, social care and health dedicated to tackling CSE – to follow up on individual cases.

Training was offered on site to the pharmacists, complementing the face-to-face training already being delivered on safeguarding and CSE.

The impact

The community pharmacists who have been supported say it is making a real difference to the work they can do, enabling them to spot those who may be a risk and raise the alarm.

One said: “The training has updated my knowledge of CSE, provided useful ideas and information to consider. It has been very informative and made me think about the things I hadn’t considered before.”

Another added: “As I work front of house I deal with many different members of the community. The training will help me spot the signs of CSE easier.”

The work has also attracted national attention. Buckinghamshire has shared as best practice via England’s Sexual Health and HIV Commissioners Network.

Evidence was also given to a Buckinghamshire Health and Social Care Select Committee about the importance of spotting the signs of CSE through sexual health services and expert public health advice to a Buckinghamshire Serious Case Review on multiple cases of historic CSE in the county.

Lessons learned

“Working on sexual and reproductive health often brings new daily challenges, said Ms Blackmore.

“By being in local government, it facilitates sexual health leads thinking much more broadly and with access daily to a broad range of other key services and partners. Sexual health is much more than just sexual health service provision and it is great we have been able to use everyone’s expertise in the local authority more effectively.”

However, Ms Blackmore said when it comes to CSE you have to be prepared for the gangs to be “highly sophisticated”.

“We know they can target pharmacists in different geographical areas to access EHC for girls and we have to be one step ahead and always ensure there are strong local communication networks and referral pathways in place.

“A pharmacy setting offers anonymity especially in main town centres. People can attend for a range of other things at the same time, for example toiletries, make-up and young people, in particular, value immediate access with a level of anonymity – it’s not like using their family GP surgery.”

How is the approach being sustained?

Alongside sexual health practitioners, the wider team who have a role in sexual health have been involved too.

GPs, practice nurses, community pharmacists, school nurses, teenage pregnancy midwives, family nurse partnerships, looked after children and youth offending nurses, substance misuse services, domestic abuse and youth workers have all played an active role in recent workshops on topics ranging from exploitation and trans health to teenage pregnancy. Representatives are all members of the Bucks Sexual Health Network led by public health.

More recently Buckinghamshire has been exploring how else sexual health services can work with partners. A joint public health and education post – Personal, social health and economic (PSHE) lead public health/schools – has been created and part of the role is to help schools prepare for the introduction of compulsory relationships and sex education (RSE) in 2020.

It involves working and training teachers and in particular, working closely with PSHE coordinators on preparing for the change.

Ms Blackmore said: “This is a really important moment for sexual health to ensure safe, consensual, healthy relationships and age appropriate work on sexual health is delivered in schools which is a key setting identified by young people in the last National Survey of Sexual Attitudes Lifestyle. It is so important we invest and prepare for it.

“The funding of the PSHE post to support the implementation of RSE is an excellent example of a further approach required to make a difference. In Buckinghamshire we will be looking to build on this type of work in the future.”

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Dorset Council: getting providers working as one

Dorset Council has got its providers working collaboratively, resulting in less fragmentation, improved services for patients and greater emphasis on prevention.

The challenge

Historically in Dorset there were four different contractual arrangements for the provision of sexual health services – one for the community, two to run Genito Urinary Medicine (GUM) clinics and a fourth for the online offer. The services were run separately and so were fragmented in delivery.

On average about a quarter of service-users accessed GUM services for simple checks and advice, which could have been delivered more effectively and efficiently elsewhere.

During 2014/15 Dorset started to look at ways of integrating services, including approaches to tendering as well as using a section 75 agreement with Dorset CCG, which became less feasible when NHS England decided to retain responsibility for commissioning HIV services.

So Dorset had to consider different approaches to meet the challenges of the national public health grant reduction.

The solution

The council saw this as an opportunity to change its approach. A block contract was introduced in 2015/16, replacing the payment by results system that had been operating until then.

The contract was structured so that savings of 20 per cent were phased in over three years and the council worked with the providers to look at how services could be restructured to tackle service changes and meet the national budget expectations.

A memorandum of understanding was signed between all the providers to work together to integrate services and make financial reductions where required through innovation.

The community provider, Dorset Healthcare, was appointed lead provider with full support from the other providers and since then the system has worked together successfully sharing decisions on changes that they needed.

Assistant Director for Public Health Sophia Callaghan said: “Services seemed fragmented – the services were split across the east and west with often variation in capacity for the rural and conurbation areas that could be better designed to meet demand. We felt improvements could be made under the principles of efficiency, effectiveness and value.

“The move to block payments helped us to manage financial risk and gave providers the opportunity to work more flexibly to innovate and change within their services. What is more, payment by results created a ‘test and treatment’ focus, as opposed to an outcomes focus which was more geared up on prevention.”

The impact

By the end of 2018 significant changes with the way services were organised began to transform the system. Previously there were 13 small clinics dotted across Dorset housing different teams and services. Instead these have now been amalgamated to four larger integrated clinics where staff from the different services work side-by-side.

These clinics operate as spokes to one main hub in Bournemouth and satellite hub in Weymouth. As part of these changes, a greater emphasis has been placed on prevention with healthcare assistants (HCAs) trained to encourage behaviour change.

Helen Martin, the Service Manager at Bournemouth, said: “Our healthcare advisers are key to encouraging behavioural change. HCAs run independent asymptomatic male and female clinics and within the assessment they can identify patients whose behaviours put them at risk in terms of smoking, alcohol, risky sexual behaviour and contraception.

“The HCAs are able to advise, onward direct and signpost these patients where they can seek further intervention. For patients who present in these clinics with a number of risky behaviours or more complex issues they are then referred to our health advisers at this clinic appointment and seen on the same day.”

There is also a more flexible and responsive outreach service that provides support to those more vulnerable groups that may engage in risky behaviours.

Ms Callaghan said: “The integrated set up is easier and more accessible for patients. The clinics are essentially one-stop shops where patients can access a more comprehensive range of services and can be properly triaged so they receive the right support the first time.

“One example is the Over the Rainbow, a gay men’s health promotion service. That used to be run from one building in Bournemouth, has now moved from the building to a virtual service, which is now available across the county via the clinics. It means it is much more accessible to people over the whole county.”

The working culture is also vastly different with staff now supporting different sites. “We’ve been able to tackle some of the demand issues in higher need areas and we are much more flexible. The service is essentially one – not fragmented as it once was,” added Ms Callaghan.

Lessons learned

The council worked with the providers, helping them to assess and review new ways of working. A series of task groups was set up. These covered topics such as needs based service modelling, clinic design, pathway development, prioritising prevention and online and IT development.

Initially groups were council led – to outline expectations – but soon moved to providers running planning themselves, sharing expertise and decision making.

Ms Callaghan said: “The key was that it was not prescriptive, but provider led. It was a collaborative effort. Providers know how services work and how to get the most out of them so we let them design things and supported them along the way. I think that is a key bit of learning – letting go and building trusting relationships for providers to deliver.”

Jane Cromarty, the Clinical Practice Practitioner for Dorset Healthcare, is full of praise for the approach. “The process of integrating sexual health services in Dorset has enabled the people most knowledgeable, committed and passionate about ensuring high quality reproductive and sexual health for the local population to collaborate and develop a new and innovative patient-centred service.

“The teams have worked tirelessly, in addition to their usual workload, to deliver a large scale project within a tight time frame.”

How is the approach being sustained?

Now the new clinics are establishing, Dorset is looking to the future. It aims to build and expand on the online testing services and use of social media

Once premises are available the Bournemouth hub will move out of hospital where it is currently housed and into an integrated community venue.

Meanwhile, the outreach team is in the process of developing its model with a focus on prevention and education, working with the highest-risk populations and schools by supporting them to prepare for the introduction of compulsory relationships and sex education.

Ms Callaghan said: “We are really happy with the progress made with service development and future direction. There are good relationships across the system and that is helping us improve services and innovate.

“One of the next things we are thinking of exploring is whether there is benefit in bringing the LARC service run by GPs and the emergency contraception service provided by pharmacies into the integrated system as a pan-Dorset model.”

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Hampshire County Council: joining up commissioning

Across Hampshire, commissioning has been joined up by creating a commissioners group for the local councils, CCGs and NHS England. It has help maintain integrated services and led to the development of an improved digital offer and specialist services.

The challenge

The transfer of public health responsibilities to local government in 2013 presented a potential risk to the continued commissioning and delivery of integrated sexual health services in Hampshire.

The county already had an integrated sexual health service model where residents could access a range of services. But under the new system commissioning responsibility was handed to different organisations, and there was a concern that these services could become fragmented

In addition, a significant number of Hampshire residents crossed council boundaries to access seek services in the two main cities of Portsmouth and Southampton.

The solution

A sexual health commissioners group was established in 2014 to support the continued commissioning and delivery of integrated sexual health services. It included representatives from all three councils and seven CCGs with input from NHS England.

The group has worked together to undertake a collaborative procurement exercise for sexual health. It was agreed services would be tendered on a county-wide basis including

the two cities. A single provider was selected to work across the region, covering a total population of 1.7 million.

The service now provides council commissioned services for contraception, STI testing and treatment, chlamydia screening, psychosexual counselling and sexual health promotion and HIV prevention services as well as CCG services for termination of pregnancy and vasectomy and an HIV treatment service commissioned by NHS England

Hampshire Public Health Principal Rob Carroll said: “The collaborative procurement required a lot of work, but it has meant we continue to have an integrated one-stop shop approach to sexual health service delivery, which is better for residents and more cost-effective for commissioners, than standalone services.

“We have a single electronic patient record which means that no matter where a patient goes their records are immediately to hand, creating a more seamless service for patients.”

The impact

The collaboration has also enabled Hampshire to invest in other services. A big emphasis has been placed on the digital offer.

STI testing kits are available online for low-risk asymptomatic residents and there is also a webchat facility that guides residents to the most appropriate service for their immediate needs - whether that is an appointment at a clinic, services in primary care or STI self-sampling. Satisfaction rates with the service are running at over 95 per cent.

Specialist services have also been developed for at-risk groups.

These include:

- SHIELD clinics for people with learning disabilities
- ROSE clinics for people at risk of sexual exploitation
- TULIP clinics for people involved in commercial sex work
- XTRA clinics for men who have sex with men

These are run in the main clinics at set times and are delivered by practitioners specially trained in helping these individual groups. The appointment times are also longer.

Lessons learned

Mr Carroll said a guiding principle for all the work has been on designing services around the patient.

“We think about how we can make it easier for the patient - and work from there. There was a time when a woman coming in for an abortion would have to make a separate appointment for contraception and then another one if she wanted an STI test.

“Now that can be done within one pathway within one service – not only is that better for the patient but it is also more efficient too.”

How is the approach being sustained?

Improving access to LARC has been highlighted as a key priority. Hampshire, Portsmouth and Southampton are putting together a business case to the STP to increase investment in LARC, recognising that the majority of savings from preventing unintended pregnancies are gained by CCGs.

Mr Carroll said the creation of primary care networks - being championed as part of the NHS long term plan – is also offering opportunities to improve access to LARC.

“Not all GP practices provide LARC, but with practices working together across larger footprints, there are increased opportunities for practices to work together to provide specific LARC clinics for patients from other practices.”

Other developments being considered by the commissioners group include proposals for a community gynaecology service, telephone contraception counselling to increase the availability and uptake of contraception within abortion pathways and the introduction of self-referral and online assessment for vasectomy.

“Sexual health commissioning is fragmented, but that does not mean we cannot work together and ensure services are not,” added Mr Carroll.

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Kent County Council: improving the digital offer

Kent has invested in digital technologies to improve the way services are offered. A new website has been launched and that has been followed by a range of online STI tests, which have proved to be very popular.

The challenge

Responsibilities for the delivery of Kent's sexual health services were fragmented when much of the commissioning transferred from primary care trusts to local government in April 2013.

Services had been run by two primary care trusts in Kent with different investment and provision.

Integrating and modernising services were seen as key priorities.

In particular, there was a recognition that more needed to be offered digitally.

The solution

To achieve this the creation of a single sexual health website was undertaken. Your Sexual Health Matters was launched in 2015 and includes information about STIs, contraception and integrated services as well as links to other related services.

The website has been followed by the development of a comprehensive online STI testing service for over 16s. The service has been developed gradually. In November 2015 Kent started offering HIV home testing kits and then chlamydia screening followed in January 2016.

The changes saw demand increase and insight work undertaken in early 2017 emphasised the need to extend online testing even further.

In October 2017 the online offer was increased to include testing for gonorrhoea, syphilis, Hepatitis B and C. This is dependent upon individual self-identified risk through a detailed algorithm that was developed to help ensure people get the tests they need.

Safeguards have been put in place to try to ensure that those under the age of 16 are supported to access a clinic rather than use the online services.

The C card condom scheme has also been overhauled. An evaluation of the scheme led to the development of a new programme 'Get It', including an online service. The scheme has also started to be offered in a more diverse range of locations, including at a local theme park, youth hubs and barbers.

The impact

The numbers using the online service has been rising from 500 in October 2017 to 1,500 by October 2018. These represented 22 per cent of all attendances among Kent residents accessing local STI services.

Director of Public Health Andrew Scott-Clark is delighted with how it has gone. "One of the really noticeable things is that we have seen no drop in the numbers using the clinics. That suggests that the online service has filled a gap.

“Either these people were not getting tested in the first place or they had been going out of area. Because of our proximity to London, we know many people go elsewhere. There is a sense that services are better there or they did not know where to go in Kent.”

Positive progress has also been made in terms of condom distribution. The numbers distributed have increased over the past year from 27,000 in the first quarter of 2017/18 to 47,000 in the same period in 2018/19.

Lessons learned

Kent implemented an incremental approach to the development of the online testing platform, deciding not to promote it heavily, to ensure that capacity could be met.

Mr Scott-Clark said: “Instead we have simply communicated it. When people come to clinic we have told them about the online offer and through word of mouth people who need it have started to find out about it.”

That contrasts markedly with the promotional effort put into the new condom programme. The launch of that saw the provider run events across the 12 different districts of Kent and at other events such as fresher fairs.

How the approach is being sustained?

Kent has plenty of plans for the future. Creating an online chat service on the website is being looked into as well as exploring the options of offering oral contraception online and conducting consultation for long acting reversible contraception.

A pilot scheme is being run offering drop-in psychosexual services at a local college. Currently this specialist service is only available through referral.

But one element that has remained challenging is encouraging those who test positive to inform partners of the result or to enable the service to do this on their behalf. Currently those using the online service can upload information online about who should be contacted in the event of a positive result.

“Informing and encouraging sexual partners to access the online service to access STI testing is an important part of protecting the population. It is obviously vital that people are notified so they can get tested themselves. People often think that they would know if their partner had an STI, but that of course is not the case,” added Mr Scott-Clark.

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Nottinghamshire County Council: enabling closer cooperation between partners

Working groups bringing together all the different parts of the sexual health service are being set up in Nottinghamshire to enable closer cooperation. A year in, the project has already led to women being given easier access to LARC.

The challenge

Sexual health is a fragmented commissioning landscape, with different parts of the system being overseen by NHS England, CCGs and local government.

Historically in Nottinghamshire there has been relatively little in the way of collaborative working between these different parts of the system.

The worst case scenario resulting from this would be that services under pressure might make efforts to shift excess demand into other parts of the system for which they do not have responsibility, resulting in inefficiencies, poor patient satisfaction and outcomes.

The solution

Over the last year efforts have been made to facilitate greater integration of local sexual health services.

Nottinghamshire County Council commissions an integrated sexual health service across the county, which is provided by three different NHS Trusts.

In the last twelve months, the council's public health team has led the development of working groups designed to get all relevant organisations around the table and working together more closely.

GPs, practice nurses, CCG leads, NHS providers, NHS England and council commissioners have all been invited to participate in this exercise to better understand the pressures and challenges that exist within different parts of the system, and to work together in overcoming them.

Groups covering the middle and the south of the county have been set up and include representatives from up to seven different organisations. They are meeting quarterly.

The impact

Improved patient referral pathways are now being developed with the aim of improving efficiency and ensuring that service users receive the testing and treatment they need in a timely manner and in a setting that best suits their needs.

One of the earliest successes from these working groups has been the development of an inter-practice referral system for LARC that has been set up in mid Nottinghamshire.

GP practices who lack the capacity or personnel to fit coils or implants are now able to make a referral to another practice, instead of having to direct people to the sexual health clinics.

Nottinghamshire's Acting Public Health Consultant Daniel Flecknoe said: "We know that some women wishing to use LARC were having to travel long distances to already very busy clinics and wait to get their contraception."

“Now we have this new system set up they can be referred to a nearby practice instead. It is making a big difference to those patients.”

Lessons learned

Mr Flecknoe said you should not underestimate the benefit of face-to-face meetings.

“It really helps to break down barriers. We are all working for different organisations with different priorities, but at the end of the day we all want the same thing – to provide a good service to patients and the public.

“By getting round the table together we can develop those personal relationships that can make all the difference when you are not working for the same organisation.”

How is the approach being sustained?

Work is under way to get a group covering the north of the county up and running. The hope is that it will start in the coming months and build on the successes of the two other groups.

The work has also highlighted some other issues that need addressing. One example is the discrepancies in how services are performance managed.

Mr Flecknoe said: “The key performance indicators for the same activity can be very different across the system and this creates its own incentives.

“For example, GPs are expected to provide a LARC fitting within four weeks of a referral, but the integrated sexual health clinics are currently expected to do so within five days.

“This obviously encourages service users to preferentially access LARC at the clinics, when their GP service may be a more appropriate venue for an uncomplicated fitting.

“We plan to review these KPIs in cooperation with our GP and CCG colleagues in order to create more equity across the sexual health system in Nottinghamshire.”

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Norfolk County Council: easing demand on clinics

Like many areas, Norfolk has seen rising numbers of people coming to their sexual health clinics for testing. To help ease the pressure, an online service for the four core STIs has been developed. It has proved remarkably successful.

The challenge

In March 2015 Norfolk County Council commissioned an integrated sexual health service for the county including a section 75 agreement to pool budgets with the NHS England for HIV treatment and care.

Over the following years demand continued to rise, putting pressure on budgets that were being squeezed because of the cut in the public health grant by central government.

Around a third of patients coming to clinics were asymptomatic and so the council began to explore other ways to support those patients, in particularly looking at the potential of online testing.

The solution

Chlamydia screening for under 25s and HIV testing for at-risk groups was already being done online through national programmes. So Norfolk asked its provider to take that a step further and develop an online service for chlamydia, gonorrhoea, syphilis and HIV.

The provider, Norfolk iCASH, developed its own online platform, using the same labs and kits that were used by the clinic team.

The service launched in August 2017 with the target of decreasing clinic activity by 6 per cent to 7 per cent, which Norfolk estimated would save in the region of £100,000 a year.

All appropriate asymptomatic users are now signposted to the online service. It allows users to order a STI kit to be sent to their home, self-test, return via post and receive the result to their mobile phone within days.

The impact

The service has proved incredibly popular. Between November 2017 and November 2018 nearly 13,000 patients used the service.

In fact only about one in 10 asymptomatic patients use the clinics - and they are ones who do not have mobile phones, are under 16 or where there are safeguarding concerns.

Sexual Health Commissioner Tracey Milligan said: "It has worked really well. We didn't advertise it or really promote it. We just relied on clinicians telling people about it or people finding it on the website.

"I think the fact that we are using the existing provider has made it really seamless – and patients appreciate that. The results come back quickly and we have even noticed a drop in the out-of-area payments we have to make.

"There are probably a variety of factors for that - our clinics are really busy, some people do not want to be recognised at their local clinics and others work out of area.

“What it shows is that there is a real demand for online testing. That should not come as a surprise - after all people conduct so much of their lives online from banking to shopping, health services should be no different.”

Lessons learned

In some ways, Norfolk has been a victim of its own success. “You could say we have been too popular,” said Ms Milligan. “We have seen the numbers of asymptomatic patients using our service increase by a third since we launched the online service.”

It means that while the numbers attending clinics have fallen by the target, the monetary savings have not been realised.

“We are beginning to look at how we react to that. The numbers returning positive tests are low with only achieving a 6 per cent positivity for chlamydia – so there are some signs people are coming forward too often or are the worried well,” added Ms Milligan.

To help mitigate against this, the online system is evolving to include more questions about sexual history and past tests to identify those who do not need to be tested. Although if they do have concerns they will have the option of contacting the service.

“With better triaging, the right tests can be sent to the right people and at the right time to mitigate the increasing costs of over testing,” Ms Milligan added.

How is the approach being sustained?

As well as trying to curb the number of tests being done unnecessarily, Norfolk has plans to improve the way it engages people, particular older ones.

The council is exploring introducing a webcast facility on its website so people can get real-time advice and support.

A Facebook campaign is also being planned to encourage more older people to use the online service – currently 85 per cent of online users are under 35 and national figures suggest it is the over 35's heterosexuals who are becoming more at risk, particularly for HIV.

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Oxfordshire County Council: working closely with GPs

Oxfordshire County Council has worked closely with local GPs to ensure women have access to LARC and the system is administered fairly in terms of whether it is the council or NHS that pays for the service.

The challenge

In 2014 Oxfordshire County Council introduced an integrated sexual health service. This merged the previously separate contraception and STI treatment services into one service.

It provides a 'one-stop shop' model where residents can access services that meet all their sexual health needs in the one place delivered by the one team in nine clinics across the county.

With that system well and truly embedded, the council has turned its attention to working more closely with GPs to ensure that additional services provided in general practice remain an option for women.

GPs are commissioned by both the NHS and councils to provide contraception services. This fragmentation can cause confusion over who is responsible for paying for what and the support doctors get in providing services to patients.

The solution

Oxfordshire is recognised as a national exemplar in terms of championing training and the development of the GP workforce. The council ensures this through funding training through the integrated service contract.

The contract specifies that the provider, Oxford University Hospitals Trust, is responsible for training GPs and their practice staff. This is offered to both new and existing members of GP teams through introduction and refresher training in how to administer LARC and when it is appropriate to use.

Since the service began in 2014 the service has trained 74 local practice staff to deliver LARC as part of local commissioned services.

The council has also worked with the local CCG to establish a clear system for who is responsible for paying for LARC.

LARC can be prescribed for a variety of reasons. The most obvious use is as a contraceptive, but GPs also prescribe it for other reasons, including as part of a hormone replacement therapy for menopausal women and to help patients manage heavy menstrual bleeding.

Public Health Consultant Dr Eunan O'Neill said: "Where it is used as a contraceptive, it is the council's responsibility to pay, but if it is for a medical condition it is an NHS issue. When we looked at this we found this was confusing for GP practices who were not clear on who to bill.

"There was a concern that developing complicated procedures to sort out the billing could lead to women not being offered LARC.

Last year the council worked with the CCG to establish a legal section 256 agreement to commission non-contraceptive use in GP practices on its behalf. This secured the delivery of contraceptive and non-contraceptive use of LARCs for women across the county.

The impact

Dr O'Neill is delighted with the result. "The arrangement ensures that GPs do not have to consider which organisation is contracting their services and reduces duplication of monitoring and managing services for commissioners."

Local GP Dr Elizabeth Van Stigt said: "Over time, the use of intrauterine systems (IUSs) for non-contraceptive purposes has increased hugely, so it seems only right that the NHS shares in this cost."

"In reality most IUSs are fitted for a combination of reasons or the reasons change over time. It therefore makes absolute sense that GPs are able to offer them in a holistic way without needing to separate the particular benefits according to payment and be paid appropriately for doing so."

Lessons learned

Getting payment systems right for sexual health services is difficult, but a crucial part of developing and improving services, according to Dr O'Neill.

The system for paying GPs for LARC is based on an algorithm developed by clinicians at Oxford University Hospitals, the local provider of STI testing.

It uses the records filled in by the GPs that record the reason for the contraception being given and then codes that as either a contraceptive reason or medical reason or both. Where it is both, the NHS and council share the cost.

"You have to be realistic about this.

There are some cases where it is a grey area about whether it is for a medical need or for contraception. We don't see any point arguing about or chasing up the GP so we have agreed we just split the costs," Dr O'Neill added.

How the approach is being sustained?

The public health team is constantly looking to improve the way services are provided through its commissioning.

In April a new contract was introduced for online services including self-sampling for STI tests and access to repeat oral contraception prescriptions.

The sexual health promotion and outreach arm of the service has also been asked to engage with high-risk disenfranchised groups in the community and promote safe sexual health behaviours.

Dr O'Neill said: "School health nurses provide outreach in schools and colleges, but we want to do more by working with groups such as sex workers and the homeless. Oxford University Hospitals is going to be working with the Terrence Higgins Trust to develop this."

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Wigan Council: developing a new model in partnership with residents

Wigan Council has developed a pioneering approach to public sector reform known as The Deal. It is a new way of working differently with communities and stakeholders with both sides working collaboratively to improve the borough. When commissioning its sexual health service, this model shaped how the council transformed its approach.

The challenge

A review of sexual health services between 2015/17 found Wigan had disproportionately high rates of sexual ill health, including between different communities in the borough.

Over the previous 10 years there had been a marked increase in STI diagnoses, particularly among young people, and there was also evidence of risky behaviour.

The borough also had the third highest rate in England of under 16s accessing emergency contraception and a high rate of repeat EHC prescriptions. There was also a downward trend in LARC use and low uptake of HIV testing.

The solution

The public health team wanted to explore how the commissioning opportunities enabled by The Deal could be used to support transformation of sexual health within the borough.

The Deal is based on principles of a shared relationship with residents and so it was critical that Wigan's plans for transforming sexual health in the borough were developed jointly with residents and key stakeholders.

A consultation exercise with stakeholders and residents was therefore initiated to help inform a new start for sexual health services.

The consultation involved questionnaires – filled in by nearly 800 people – and around 60 focus groups. It resulted in seven principles being agreed. They were:

- one organisation to be responsible for care coordination, safe and effective services, and a trained and skilled workforce
- staff to have a 'different conversation' with patients focused on their strengths and the things that matter to them
- increased opportunity to access information and advice online, book appointments and order self-sampling kits
- increased outreach into communities, to bring services closer to people into their community
- single point of access to services, helping people to get to the right place at the right time
- using an asset-based approach to support positive sexual behaviours, including working more closely with schools, GPs, pharmacists and community groups
- where possible one service or person to be able to help residents with the things they need.

The development of these principles paved the way for a new delivery model for sexual health services to be developed.

Public Health Lead Officer Paul Jamieson said: "We recognised there needed to be a more integrated system, with delivery closer to people in their own communities, community

providers more involved in sexual health and a greater emphasis on prevention.”

In line with the ‘co-production’ nature of The Deal, the council sought to find a partner which could implement the new delivery model as well as leading the transformation needed to improve sexual health outcomes for residents. Spectrum was successfully awarded the contract and delivery commenced in March 2018.

The impact

Spectrum has now completed the implementation stage. Staff from three previous providers have been integrated within one staffing model, achieving improvements in consistency, clinical delivery and financial efficiencies.

Spectrum runs two specialist sexual health hubs offering the full range of sexual health provision on both an appointment and walk-in basis. The hubs are complemented by a range of nurse-led community clinics.

An integrated website (www.sexual-health.co.uk) was launched in March 2018, removing the need for residents to navigate a variety of provider websites. Campaign information and materials have been distributed across local GPs, pharmacies, schools and leisure facilities.

Meanwhile, Spectrum has also established strong working relationships with most of the secondary schools in the borough and is delivering its relationships and sexual education curriculum to year nine, 10 and 11 pupils.

Over the past year nearly 12,000 pupils attended more than 500 sessions delivered by Spectrum’s RSE team.

Lessons learned

Mr Jamieson said it is important to take your time and ensure you have consulted thoroughly when embarking on change.

“One of the most important things for us was the value of seeing really strong support from everyone for what we were doing and securing buy-in across the whole system.

“We undertook a really extensive review and re-design process. The consultation took the best part of the year and really helped influence what the final delivery model looked like.

“We are also already seeing a benefit for how change is being managed as a result of having secured the commitment and buy-in from such a wide range of residents and stakeholders.”

How is the approach being sustained?

Spectrum and the council are now working together with a range of partners and stakeholders to develop and agree specific plans for transformation in a number of areas, including primary care, schools and colleges, digital transformation, HIV and the offer to the most vulnerable and ‘at-risk’ residents.

In terms of primary care, this includes exploring opportunities for closer working with the nurse-led clinics. Spectrum and a local GP have agreed to pilot the delivery of a community clinic from the GP practice from May 2019.

Director of Public Health Professor Kate Ardern said the future is looking bright. “The innovative approach we have taken to commissioning, based on The Deal, has enabled the recruitment of an excellent partner in Spectrum that shares our vision and ambition to transform how the local health and care system supports residents with their sexual health.”

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REF 22.45