

Sexual health commissioning in local government:

building strong relationships, meeting local needs



Case studies

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Foreword

Councils all over the country understand how important a role sexual health, reproductive health and HIV services play in the health and wellbeing of their residents.

The modern day sexual health challenges are significant. According to Public Health England (PHE) there were 446,253 sexually transmitted infections diagnosed in England in 2013. Chlamydia is the most common, making up 47 per cent of all diagnosed cases. Each new case of HIV infection is estimated to represent between £280,000 and £360,000 in lifetime treatment costs. In many ways the fall in teenage pregnancy is one of the success stories of the last decade in the public health field but we know we shouldn't be complacent.

Local government is ideally positioned to think more broadly about sexual health services and, working with partners, ensure they evolve to meet the needs of their population. Redesign in many areas has focused on integration – integration with other services, such as criminal justice, adult services, leisure, children and young people, housing and integration across the wider health economy.

Public health made the formal transfer to local government in April 2013, and in the subsequent months great strides have been made. We know that rapid, open access to high-quality integrated genitourinary medicine (GUM) and sexual health services, together with improved choices for people's reproductive health, have an enormous impact on individual and population health and wellbeing.

This resource describes how public health in a number of councils has started to build on the opportunities of a local government setting to improve sexual health and wellbeing.

The case studies were chosen because they show a range of ways in which public health in councils is approaching the commissioning of sexual health services. They include councils spread across England, covering both rural and urban environments and with varying levels of deprivation and affluence.

It is striking how many local authorities are taking a whole-council approach to sexual health, based on an understanding of the interconnectedness of the social determinants of health. Working across organisations like the NHS is important, but so too are the new relationships that have developed within councils following the transfer of public health responsibilities.

We look forward to seeing many more such examples of local energy and innovation in the months and years to come, and seeing the measurable impact it will have.

The challenge for us all is not just to develop good practice but to champion and share it.

Councillor Izzi Seccombe

Chair
LGA Community Wellbeing Board

Introduction

Sexual health commissioning challenges for local government

These nine case studies showcase local government experience of commissioning sexual health services since taking over this responsibility in April 2013. From a mix of urban and rural settings, they illustrate commissioners acting on a range of sexual health priorities – meeting rising demand with tightening resources, expanding the role of sexual health services to address the broader needs of vulnerable young people, redesigning services in large cities to deliver a new model of care, integrating HIV and sexual health services to avoid fragmentation and maintain service viability, and updating HIV prevention approaches. The studies demonstrate how commissioners have grasped the opportunities of having a local government base. They outline the steps taken to collaborate not only within and between local authorities (LAs) but also with NHS England and Clinical Commissioning Groups (CCGs).

Developing the case studies

MEDFASH was commissioned by the LGA to research and develop the case studies. This followed on from our work to develop 'Making it work: a guide to whole system commissioning of sexual health, reproductive health and HIV' published in September 2014 by Public Health England (PHE) and partners. To identify potential case studies, contact was made with PHE centres across

England. Thirty potential LA case studies, matching criteria MEDFASH had developed, were proposed. The Association of Directors of Public Health (ADPH)'s sexual health leads, David Regan, DPH Manchester and Dr Jonathan Hildebrand, DPH RB of Kingston, kindly agreed to act as external advisers to the project. Nine potential case studies were selected and the relevant directors of public health (DsPH) and sexual health commissioners approached. All agreed to work jointly on the development of a case study. The studies presented are based on interviews with councillors, officers and external partners. Thanks are due to all those who devoted time to interviews and commented on drafts.

How commissioners are 'making it work'

'Making it work' highlighted twelve key messages. As the snapshots provided by these case studies demonstrate, many LAs have developed commissioning practice consistent with these messages. Two years on, we have identified diverse ways in which the commissioning challenges outlined in 'Making it work' are being addressed and the opportunities of locating sexual health commissioning in local government grasped. Some key themes emerge from the lessons learned. The studies also highlight on-going challenges for commissioners of sexual health, reproductive health and HIV services.

1 [Making it work: a guide to whole system commissioning of sexual health, reproductive health and HIV, p.6](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)
www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

Models of collaboration

Collaborating to develop local solutions involves building trust and strong relationships – a key message of ‘Making it work’. In Norfolk, the local authority and NHS England came together to commission jointly by developing the first Section 75 agreement for HIV and sexual health services. This addressed the risk of fragmentation of services if separate commissioning strategies and timetables had been pursued. In Gloucestershire, collaborative commissioning arrangements between the local authority and CCG are underpinned by a Section 76 agreement. In London, local authorities are collaborating in various ways from a tri-borough sexual health commissioning team in Lambeth, Southwark and Lewisham to a London-wide HIV prevention programme to which all 33 London councils contribute. Collaboration requires a mutual understanding of, and respect for, different organisations’ priorities, cultures and business processes. It takes time but interviewees cite many advantages gained in achieving integrated care and economic use of human and financial resources. The case studies also demonstrate sexual health commissioners have readily grasped opportunities to work with other local government departments, particularly to meet the needs of young people and to address the broader determinants of sexual ill health such as drug and alcohol use.

Leadership and engagement in developing new sexual health models

Basing decisions on assessed need with service user pathways as the starting point for commissioning has been the foundation where LAs have redesigned their sexual health services. The users’ voice has been actively sought, with some striking examples of engaging with young people in, for example, Birmingham and Solihull, Leeds and Warwickshire. Developing new models

of sexual health care requires strong DPH leadership, political drive and structured, timely stakeholder engagement, especially with clinicians whose expertise is vital, as well as with communities vulnerable to sexual ill health and senior NHS managers. The engagement of political leaders in developing new sexual health models and expanding the role of services to address wider priorities such as child sexual exploitation and domestic violence and abuse is striking. It is also noteworthy how much commissioners have benefitted from local government procurement and legal expertise. This has enabled them to grasp the opportunities of specific procurement approaches, such as Competitive Dialogue and the Negotiated Procedure, to engage providers in shaping service models to meet specifications. Legal mechanisms such as Sections 75 and 76 have enabled joint commissioning to the benefit of patients who will experience more integrated care.

Improving sexual health outcomes

It is also noteworthy that LAs are aiming to improve sexual health outcomes through commissioning sexual health models which span primary and secondary care and draw upon third sector expertise through communities of providers working in consortia or using a lead provider model. It will be important to track progress in meeting this aim and to evaluate the impact of new models independently. Contracts awarded for three to five years, with options for extension, allow time for systemic change and improvement. There is a determination among commissioners to focus on achieving improved sexual health outcomes rather than the mechanics of multiple contract management. This requires carefully designed metrics and close monitoring to track progress.

Meeting rising demand

The challenge most often highlighted by commissioners is meeting rising demand within constrained resources. Approaches to addressing this include the economies of scale and greater negotiating power of a larger commissioning footprint, developing self-management options and increased prioritisation of prevention in service specifications. Engaging clinicians in finding solutions and ensuring the voices of service users are heard in developing strategies, planning and delivering major change are vital. As the case studies demonstrate, strong DPH system leadership, detailed needs assessment and an evidence base for action, clear problem definition and transparency in developing solutions in partnership are required. It is also recognised that engagement must be formalised to respect procurement procedures at certain points in the commissioning process.

Developing local solutions – commissioner-provider relationships

Identifying and managing risks and jointly tracking progress in improving outcomes are the hallmarks of strong local relationships between commissioners and providers. These are an essential foundation to addressing the challenges faced by commissioners of sexual health, reproductive health and HIV services. The case studies can only be a snapshot but they offer rich examples of how commissioners remain committed to acting boldly to develop local solutions. Collaboration is key – with fellow commissioners inside and outside local government and with service providers – to implement these solutions for the benefit of local populations.

Judy Hague, Project Consultant, MEDFASH
Ruth Lowbury, Chief Executive, MEDFASH

Joint whole system commissioning of sexual health and HIV services in Norfolk

Using a Section 75 agreement to deliver integrated patient pathways

“First we undertook a comprehensive assessment of Norfolk’s needs, and then we brought everyone together at a sexual health conference where this was presented and further views sought from all stakeholders. We wanted a fully integrated approach from the start”

Dr Augustine Pereira, Consultant in Public Health Medicine, Norfolk County Council.

“We came to an agreement Section 75 was the right way for Norfolk, the right vehicle to achieve the outcomes for Norfolk – a good fit”

Daniel Eve, East of England Specialised Commissioning Team, NHS England.

Key messages

- The director of public health is central to driving forward the commissioning of sexual health services. Embedding public health in local government as a core corporate resource can facilitate its role in the commissioning cycle across a range of services.
- A focus on outcomes for the population based on a thorough needs assessment is key as it puts everything in perspective.
- Building relationships, mutual respect and open channels of communication is essential when seeking to integrate services with different commissioners working across organisational boundaries.
- Taking a long-term approach thus future proofing your service model and commissioning decisions is a huge enabler when developing a partnership.

Outline

Norfolk County Council and NHS England’s East of England Specialised Commissioning Team have jointly commissioned an integrated sexual health and HIV service for the county. Following a sexual health needs assessment undertaken by the Public Health department in 2013, the two organisations came together and agreed to commission through a Section 75 (S.75) agreement. This approach was considered to be the “best match for Norfolk”. It was the first such agreement for commissioning sexual health and HIV services between a local authority and NHS England and was developed to address the risk of service fragmentation in the post-Health and Social Care Act commissioning landscape. Having agreed to commission jointly, the local authority took the lead in the procurement process through a Competitive Dialogue based on Lean principles. All parties were satisfied the process was well matched to the development of the new integrated sexual health service with a hub and spokes model.

Context

Norfolk's resident population is 857,888 of which 14 per cent are aged 15-24 years and 38 per cent are aged 15-44 years (ie the reproductive age group). Sexual health services are provided to a large and diverse population with three urban centres – Norwich, Kings Lynn and Great Yarmouth – within an otherwise predominantly rural community. There are seven local authority areas in Norfolk. Among these, Norwich, West Norfolk and Great Yarmouth have particularly high levels of deprivation.

A total of 5,539 acute sexually transmitted infection diagnoses were made in Norfolk in 2012. Chlamydia was the most prevalent STI (62 per cent) diagnosed. In 2013, the chlamydia diagnosis rate was 1,387, lower than the England average of 2,016 and below the level PHE recommends local authorities should be working towards (2,300 per 100,000 population). The rate of gonorrhoea per 100,000 population in Norwich (51.5) well exceeded the England average (45.9) in 2012 when diagnosed HIV prevalence in this local authority area had just exceeded the threshold of 2 per 1,000 population, warranting expansion of HIV testing to new GP registrants and to all acute medical admissions in hospitals. In 2011 – 2013, the HIV late diagnosis rate was 49.6 per cent, significantly above the England average of 45 per cent.

The public health department is located in the resources directorate. The rationale for this is that it would enable public health to influence the council's commissioning cycle by using needs assessment, evaluation and evidence-based approaches to challenge existing thinking and embed public health in all relevant local government processes.

Joint procurement of sexual health and HIV services using a Section 75 agreement

Objectives

The overarching commissioning objectives for sexual health and HIV services were as follows:

- to commission integrated sexual health and HIV outpatient care within a single service to meet assessed needs
- to improve access to sexual health services through the provision of contraception and sexual health services including HIV care and treatment from a 'one-stop-shop' at different sites
- to provide joined-up services through development of a coordinated approach to service delivery
- to increase access to sexual health services in primary care through the provision of enhanced training and development support and streamlining of public health contracts with primary healthcare providers.

Further details of the specific aims and objectives of the S.75 agreement are given below.

“The procurement partnership was key to the whole thing. It was a revelation to me – the idea you can sit down and do a dialogue with providers and tease out how the service will operate”

**Lucy Macleod, Interim DPH,
Norfolk County Council.**

Approach

Sexual health services accounted for 23 per cent of public health expenditure in Norfolk in 2013. The inherited budget was insufficient to meet demands. The existing contracts with six different specialist providers, four voluntary sector providers providing outreach to vulnerable populations, and a collection of GPs and pharmacies providing Levels 1 and 2 services, had inherently high transactional costs. In an attempt to reduce these costs and to improve the quality, efficiency and effectiveness of the service, the council decided to re-commission it. Needs based, service model and financial drivers for change were identified by the public health department at the start of the re-commissioning process. This sought to achieve 'better services within a reduced cost'.

Following an in-depth sexual health needs assessment by an associate public health specialist incorporating the views of service providers and over 350 service users, the public health department organised a sexual health conference attended by service leads, specialist clinicians, GPs, pharmacists and the voluntary sector. From the beginning, the public health department was committed to an integrated approach and understood the risks of fragmentation if genitourinary medicine services were commissioned separately from HIV services. These risks were also raised by East of England clinicians at an event sponsored by the British HIV Association, making NHS England aware of the issues.

The council's public health leads for sexual health and NHS England's specialised services commissioners came together to review financial and patient level information and assess options for commissioning. The council had developed a draft service specification for integrated sexual health services and NHS England the national HIV service specification through its Clinical Reference Group. Public Health England played an important role in brokering this

joint work, reviewing data and deciding the elements of the national HIV specification that needed to be part of the procurement. Commissioners worked hard to unpick and understand financial information and the historical funding of sexual health and HIV services. They also needed to understand the commissioning cycles of their respective organisations.

There was a potential mismatch in commissioning approach and commissioning timetables between a local authority commissioning for its resident population and NHS England commissioning on a provider basis within a national specification. The two organisations agreed a S.75 agreement "for commissioning of HIV related services" was the right route for Norfolk. The council had experience of S.75 agreements for other services and a draft was produced by the Norfolk legal team which was reviewed by that of NHS England. There were several iterations before the agreement was finalised and became the first S.75 agreement for sexual health and HIV services in the country.

The underpinning aims and objectives of the agreement were:

- to enable the local authority to act as lead commissioning authority for the provision of HIV outpatient care and treatment services in Norfolk
- to provide an integrated sexual health service (GUM, contraception and HIV), preferably within a single consultation service model, to the Norfolk population
- to make effective use of resources by means of the above
- to ensure successful outcomes from the agreement including joint procurement and contract award and joint service monitoring between the local authority and the NHS England specialised commissioning team.

A sexual health project board had been established to oversee the commissioning process. The service specification included not only delivery of integrated sexual health and HIV services but also staff training

and workforce development, sexual health promotion and good communication with other service providers to develop integrated pathways.

A workshop was held to explore potential procurement approaches attended by the Chair of the Health and Wellbeing Board and specialist advisers from the council's procurement department. Three key decisions emerged – firstly, to let a single contract (rather than three lots), secondly, to set a contract length of five years with two possible two-year extensions and thirdly, to use the Competitive Dialogue procurement process. This had been used in Norfolk for other services and was considered well matched to the commissioners' aims of creating a new model for a complex service. This could be best achieved through a process of dialogue with prospective bidders where the shared understanding of the necessary changes and innovation in the service model could be more appropriately evaluated. Commissioners benefited from training in the use of Competitive Dialogue. The Interim Director of Public Health participated in the Competitive Dialogue sessions. These were considered a “complete revelation compared to traditional procurement” by the public health team.

The Competitive Dialogue process has three stages; a pre-qualifying questionnaire (PQQ), an Invitation to Submit an Outline Solution (ISOS) and an Invitation to Final Tender (ITFT). The ISOS stage includes a presentation submitting an outline solution on which an initial two-way dialogue is based, followed by an outline proposal which is scored in order to select bidders for a full dialogue based on a method statement schedule. In Norfolk, the schedule covered “service delivery, training and innovation, workforce, clinical corporate and information governance, partnership working, service user engagement, performance management, early HIV diagnosis and HIV treatment and care”. The schedule outlined all features of the service and a dialogue ensued on each topic covered. The extent of the dialogue differed across the various topics

but included the delivery model for sexual health and HIV, staffing, buildings, data, governance, risks and finance. Bidders were encouraged to amend their methods statements as the dialogue progressed. The ITFT stage is the submission of tenders including the final version of the methods statement schedule and pricing schedule.

The dialogue meetings took place at Carrow Road – Norwich City Football Club's ground. A number of separate boxes were available which allowed a suitable environment for dialogue. Each team of negotiators (Council and bidders) had privacy. Each box was separate, could not be overheard and had a specific role (dialogue, preparation, etc). The teams could engage in short meetings and take time out to consider an issue as a team.

The contract was awarded to a lead provider working in partnership with a voluntary sector organisation providing outreach services.

“Interactions with bidders were well received and we will recommend this approach to other areas. It gave us the ability to talk and test ideas”

Joan Murray, Head of Sourcing, Procurement Department, Norfolk County Council.

Challenges

Identifying the initial financial envelope based on previously block-funded contracts and historical HIV funding was a challenge. Those involved were new to sexual health and HIV commissioning and the interconnected funding and service delivery of HIV and GUM services proved complex to unpick in order to initiate proposals for a new service model.

Both organisations recognised there was no perfect solution when identifying the right vehicle to take forward the joint procurement and achieve the agreed outcomes. A S.75

agreement was agreed to be the best vehicle for Norfolk.

Understanding what was and was not possible within the Competitive Dialogue process was a challenge for those without a procurement background and training was provided.

Identifying a suitable location for the Competitive Dialogue process was a challenge. The procurement team knew from experience how important it was to the success of the process to have the right off-site venue. Each team requires a separate and confidential space where negotiations or team discussion during 'time outs' cannot be overheard.

“There was early engagement with the local authority. We had positive communication with local authority commissioning colleagues which was very supportive and we addressed issues that arose on a regular basis through effective communication channels. PHE was important in brokering that activity”

**Daniel Eve, Service Specialist,
East of England Specialised
Commissioning Team, NHS England.**

Achievements

Commissioners developed a good understanding of each other's organisational constraints and opportunities to achieve the best outcome for users of sexual health services in Norfolk. Developing a S.75 agreement between the county council and NHS England was a trailblazing route. It reflected the findings of the needs analysis and dialogue with local professionals and voluntary organisations. Constructive working relationships and a procurement partnership between the LA and NHS

England were developed.

An integrated service for patients with continuity of care has been achieved with a minimum of disruption. The new service has improved accessibility in terms of locations and opening hours.

The Competitive Dialogue process created added value and commissioners delivered the optimum solution within the available resources. Interactions with bidders in the tendering process were well received. Although resource intensive over the two weeks of the dialogue, it has been repaid through the ease of the transition process in which no major issues have emerged.

Commissioners took a long-term approach using a five-year contract with two possible extensions, future proofing the new service and giving it ample time to bed in and develop innovations. This also repays the investment of time – six months undertaking a needs assessment and 12 months for the procurement – for all parties.

A benefit of the dialogue process is that commissioners and the provider get to know each other well, and to trust each other. Norfolk insisted that the people involved in the dialogue, from both sides, were those who would deliver the contract. As a result, the mobilisation stage proceeded smoothly, and inevitable glitches were easier to deal with.

As a result of the change in service model and the work done in the dialogue, it was possible to reduce the cost of the service by about 12 per cent compared to the original contract value. The payment mechanism in the contract had to be carefully designed to avoid a perverse incentive. Contract performance management will continue to be jointly done by NHS England and Norfolk County Council.

Lessons learned

Working across organisational boundaries requires a focus on building relationships, a shared vision for the local population, open channels of communication, mutual respect

and an understanding of the requirements of partner organisations.

In local authorities, commissioners can draw upon expert procurement advice to develop the best approach to meeting commissioning challenges. Competitive Dialogue was used and found to be ‘fit for purpose’ for commissioning a new model in a complex service. It gave clarity of expectations on both sides. Norfolk CC’s Interim Director of Public Health is keen to use the approach for other major public health programmes going forward.

Bidders required full information and briefing on the focus of each stage of the commissioning process to meet its requirements in full. For example, those unfamiliar with Competitive Dialogue may not fully appreciate their initial proposal needs to be contextualised to local circumstances and can include innovative solutions for discussion and refinement. It should not rely on a description of work delivered in other contexts. This was covered by the PQQ and formed the basis of advancement to the second stage of the process.

The location of the dialogue is very important – preferably away from the office and day-to-day operations, facilitating both communication and reflection. Each team requires privacy and the opportunity to move quickly from a dialogue session to taking stock in order to respond to issues raised.

“I would recommend others to think about the Competitive Dialogue process – it is usually only used for large value contracts. Sexual health is not large value but rather complex and it was a good decision to use this approach”

**Dr Augustine Pereira,
Consultant in Public Health Medicine,
Norfolk County Council.**

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The London HIV Prevention programme

London local authorities collaborate to address a key public health issue

“This is the only London-wide prevention programme of its kind. What we are doing is pioneering, colleagues in other areas want to see the Memorandum of Understanding that governs the programme and learn from our experience of bringing people together to deliver something that couldn't be done by a single council alone”

Paul Steinberg, Lead Commissioner, London HIV Prevention Programme.

“One lesson was quite important – if you are going to collaborate on such a programme, it needs resources. You need to be serious about it and put resources behind it”

Sarah Sturrock, Head, Health and Adult Social Services, London Councils.

Key messages

- Local authorities can respond at pace and collectively to public health needs across the capital.
- Commissioning on a collaborative basis requires a clear evidence base and equitable and transparent arrangements for accountability, governance and resource allocation.

- Where programme management is delegated to a lead local authority, a Memorandum of Understanding (MOU) with partner authorities facilitates an agreed operating model within which programme governance and management can be exercised
- Local authority leaders will engage with the sexual health agenda on the basis of evidence and the recommendations of Directors of Public Health (DsPH). They will address sensitive topics, focussing on meeting the needs of residents, while accepting that some services may be best provided outside the local authority of residence.

Outline

The London HIV Prevention Programme (LHPP) was established by the London DsPH in 2013 following a London-wide needs assessment. London Councils, the cross-party umbrella organisation for London's 32 local authorities and the City of London, played an important role in ensuring the programme was not 'lost' at the time of transition.

In February 2013, London local authorities, recognising HIV as an important public health issue, moved at pace to commission a needs assessment and review the evidence for the continuation (or otherwise) of the programme. Council leaders agreed a new programme, with significantly reduced funding compared with previous years, for a minimum of three years to 2017. A steering group was established led by Dr Julie Billett, HIV Prevention lead for the ADPH (London) and DPH for Camden and Islington. Lambeth

Council agreed to host the commissioning and management function on behalf of all London local authorities. Based on the new priorities identified, existing contracts were re-specified and subsequently retendered and a large new media component was added in recognition of the changing patterns of social behaviour in the priority target groups. After a period of change and intense activity, the programme has stabilised with regular communication to authorities through the steering group, regular briefings at the London commissioners' network and a regular FAQ briefing sheet. A National Institute for Health Research (NIHR)-funded evaluation delivered by University College London (UCL) and Public Health England will assess progress in meeting the programme's objectives.

Context

HIV is a major public health issue for London. 3,250 new HIV diagnoses were made in London clinics in 2013. The key risk groups for HIV in London are men who have sex with men (MSM) and black African heterosexuals. Over half a million black Africans live in London, representing 7 per cent of the London population. HIV prevalence is higher in London than outside with one in eight MSM living with HIV, compared to one in 26 outside London. London local authorities (LAs) account for 18 of the 20 LAs with the highest diagnosed prevalence rates of HIV in the country.

Thirty London LAs had a prevalence rate of diagnosed HIV greater than two per 1,000 population in 2011. This is the threshold at which it is recommended to expand routine testing in the local population. In 2011, it was estimated that one in five Londoners with HIV was unaware of their HIV status. Although there has been progress, notably in central London LAs, a number of London LAs (14/33) exceed the England average (45 per cent) for the number of people diagnosed with HIV late (defined by a CD4 count at diagnosis of less than 350 cells/mm³). Black Africans are more likely than MSM to be undiagnosed or diagnosed late and less likely to be diagnosed with a recently acquired HIV infection.

The London HIV Prevention programme (LHPP)

Objectives

The objectives of the LHPP are to:

- increase the frequency of HIV testing
- promote consistent condom use and
- promote the adoption of safer sexual behaviours.

Approach

When public health was transferring from the NHS to local government, London Councils was informed that LHPP's predecessor programme – the 'Pan London HIV Prevention programme' funded by London primary care trusts - had not been identified as a legacy project in transfer documents. Recognising HIV as an important public health issue and the potential reputational risk to LAs, London Councils sought the views of the directors of public health and alerted LA chief executives. The London Councils Leaders' Committee agreed the programme should be temporarily extended and transferred to London LAs with its future to be determined following a full needs assessment. Lambeth Council agreed to manage the extended contracts for the financial year 2013/14 whilst the needs assessment was undertaken to ensure stability and service coverage against the epidemiological backdrop mentioned above.

The HIV prevention needs assessment for London took place between June and November 2013. Its aims were to:

- describe and understand the changing epidemiology of HIV in London
- provide an overview of HIV prevention services and programmes currently provided across the capital
- review the evidence for effectiveness and cost-effectiveness of

HIV prevention interventions

- capture a wide range of stakeholders' views on current and future HIV prevention services in London.

The needs assessment had a number of components including an epidemiological review, mapping of current prevention activities and spend across London, an evidence review of effective HIV prevention interventions, segmented insight research on sexual health issues and sources of information on HIV for high-risk groups, and a stakeholder engagement report. Crucially, there was no assumption that the programme would continue.

DsPH reviewed the evidence generated by the needs assessment before making a recommendation to the Leaders' Committee for a limited new three year London-wide programme, which the leaders then agreed. The programme runs from 2014 to 2017 delivering city-wide activities complementary to national and local activities. It has three key elements: media/communications, condom procurement and distribution, and targeted outreach (for MSM only).

The media/communications work stream is a new component in response to changing patterns of sexual behaviour and how the target groups access information on HIV and sexual health. In addition, time-limited research was undertaken (from late 2014, to report in June 2015) on condom distribution schemes targeted at black African communities to identify the best model for future commissioning. The programme has also attracted a NIHR grant for a separate, academic evaluation conducted by UCL, in conjunction with Public Health England (PHE) and the London HIV Prevention Steering Group (LHPSG).

The LHPSG, chaired by Dr Julie Billett, has strategic oversight of the programme. A DPH representative from each of the four sectors of London and the Chair provide public health leadership and act as a conduit to councils in their sector. Lambeth Council, PHE, academia and London Councils are also represented on the steering group.

The LHPSG guides Lambeth Council, and oversees, directs and makes key decisions on the LHPP. It also reviews emerging trends and evidence impacting on the HIV epidemic and makes recommendations to DsPH on HIV prevention in London. The LHPSG reports to ADPH London and the London Sexual Health Group (a cross-organisation body chaired by a London LA chief executive on which ADPH London sexual health and HIV prevention leads, NHS England, CCGs, PHE and professional associations are represented).

Commissioning, delivery, monitoring and day-to-day management of the programme is by the LHPP Lead Commissioner, employed by Lambeth Council. An MOU was also drawn up during summer 2014 between Lambeth and the 32 other participating London councils describing the governance of the programme, financial contributions, Lambeth's role and the responsibilities of all parties.

In addition to LHPSG meetings, LAs are kept informed of progress through an FAQ briefing sheet and the attendance of the Lead Commissioner at commissioners' forums such as the London and English Sexual Health Commissioners' networks.

After a transition year, the first year of the new programme (2014/15) concentrated on the procurement of the three service components based on scoping workshops which assisted in defining requirements. The condom distribution programme and outreach work were successfully retendered to a new specification under a single contract to ensure better synergies and efficiency. The new work stream for media and communications was also successfully tendered and, as requested by the LHPSG, contracts awarded to three specialist media agencies through the Crown Commercial Service framework procurement route.

“LHPP was a totemic programme for bringing the directors of public health together and a good example of PHE nationally bringing expertise to the table and working with us”

**Julie Billett,
HIV Prevention Lead, ADPH London.**

Challenges

The first challenge faced was in securing an agreement across all 33 London councils to an initial way forward during the transition. The role taken by London Councils in helping to achieve this at a time of major change was invaluable, using its existing infrastructure (ie the Leaders’ Committee and officers leading on health and social care) to negotiate agreement to acting collaboratively on the needs assessment.

There were multiple stakeholders with an interest in the HIV prevention programme including incumbent providers, DsPH, sexual health commissioners, voluntary and advocacy organisations, PHE, clinical staff in sexual health and HIV services and academics. Some expressed concern about the level of commitment, interest and understanding local authorities would have in relation to sexual health and HIV, particularly on sensitive areas such as prevention messages and activities. London Councils and the newly appointed DsPH saw the opportunity and the challenge represented by taking a decision on the future of the pan LHPP.

Concern was also expressed that the previous programme had lost some momentum in its latter years. Although most stakeholders still believed there was a rationale for such a programme, it required effective articulation supported by an updated strategic direction and evidence base. It was also important to review whether the activities

commissioned were an adequate response to the rapidly changing social and sexual behaviours of the target groups. While no assumptions about the future were made by those commissioning the needs assessment, it had to be as comprehensive as possible and evidence-based so DsPH could make a clear recommendation to the Leaders’ Committee.

There were also challenges in forging a consensus between all 33 London councils on how to take forward the programme following the needs assessment. Although 18 of the 20 English local authorities with the highest HIV prevalence are in London and only one London LA has an HIV prevalence below 2 per 1,000 population, the LHPP inevitably focuses its activities in those where high risk activity, notably in sex on premises venues (SOPV), is known to take place. It was difficult but important to collect data to demonstrate that these and LHPP services are used by residents of all LAs.

The activities proposed for the new programme needed to complement the national HIV prevention programme, commissioned by the Department of Health, and the local activities of London councils. The LHPP was conceptualised as complementary to, not replacing, these important HIV prevention activities. In the case of London councils, local activities would continue to vary in the light of local epidemiology.

For the programme’s manager, two distinct challenges emerged in the transition year (2013/14) and the first year of the new LHPP. The first was to build the confidence of the multiple stakeholders in the programme, including LAs as funders and the existing providers with whom refocused specifications were agreed, and the second was to plan for, specify and procure the new services for the re-launched LHPP. Three key foundations were laid to meet the first challenge - the steering group, the MOU and the FAQ briefing sheet, as well as more intensive engagement with, and close monitoring of, the incumbent providers of LHPP services. Confidence was

built and stakeholders were also engaged through a series of workshops to define and shape the new services.

The programme has ambitious objectives delivered through a small core commissioning resource. It is not possible for a programme relating to 33 London councils to interact individually with each one. A further challenge therefore was to set up accountability, governance and communication channels which addressed this issue in a timely manner, allowing the Lead Commissioner to focus on deliverables, particularly procurement and management of the new social marketing/campaigns component.

Including media/social marketing in the programme, coupled with the chosen procurement route, expanded the brief of the lead commissioner. In the early months of the implementation phase, he focussed not only on contract and stakeholder management, but also on campaign, social media and website management and marketing. Daily briefings with each of the three advertising agencies and weekly sign off of creative, planning and purchasing media briefs, as well as running focus groups, writing website copy, designing t-shirts and banners, and so on is hugely time consuming.

The programme is fortunate that this manager has a background in both public health and journalism, as commissioning and running campaigns of this nature and scale are not usually combined in one post.

The Lead Commissioner has provided detailed communications/marketing leadership and oversight to the specialist agencies without the support and infrastructure normally underlying large marketing campaigns. Tapping into knowledge and expertise held at a national level about how to run such campaigns and use the Crown Commercial Services Framework also proved challenging, as this was held in more than one organisation. The lead commissioner is now supported, in the short term, two days a week by a colleague in Lambeth's communications department to meet the challenges of

managing the media component of LHPP 'in house'.

“Establish the accountability and governance early – you can always tweak it later. Agree who you will communicate with and make them responsible for internal communication within their authorities”

**Sarah Sturrock,
Head of Health and Adult Social
Services, London Councils.**

Achievements

Responding at pace to the uncertainty over the future of the previous pan LHPP, using the support and infrastructure of London Councils to assess the situation and place the issue on the agenda of council leaders, commissioning and undertaking a comprehensive needs assessment, taking a decision about the programme and setting in place governance and management arrangements for its future were major achievements.

Reaching consensus amongst council leaders, chief executives and DsPH on a way forward for the programme in a resource constrained environment required a significant investment of time and effort. This had to take account of differing levels of need across the capital (residents of only eight LAs accounting for over half of new HIV diagnoses in MSM). Financial contributions to the new programme agreed within the MOU are pro-rata to each LA's proportionate share of prevalent diagnosed HIV infections in 2011. This funding formula was perceived as equitable and, as such, was instrumental in securing the agreement of all local authorities to a new London-wide programme, although within a reduced overall financial envelope.

Setting up accountability, governance and management arrangements for the programme was recognised as essential.

These include a decision-making process permitting the steering group to take decisions and the Lead Commissioner to deliver the programme on behalf of all LAs. Communication within sectors is the responsibility of the nominated sector public health leads, which streamlines communication across the LAs involved.

Addressing the priorities identified through the needs assessment, and then coordinating with national and local programmes to ensure the complementarity of activities best done at scale on a London-wide basis, were key achievements. The needs assessment was deliberately designed to be useful to individual councils and not just a tool for the London-wide programme. The new communications and media action will 'show London we care about HIV' and that London LAs are taking concerted action to drive down rates of new HIV infection.

Lessons learned

Collaboration can cover a spectrum from information-sharing to joint commissioning. Accountability and governance arrangements are essential for joint commissioning activities. They should be put in place at the earliest possible stage even if they need to be further developed in the light of experience. Roles, responsibilities and channels of communication should be clearly delineated with a protocol in place for the latter.

Where LAs are commissioning jointly, ambitions and tasks must be matched with appropriate resources. Collaboration cannot be achieved without an infrastructure commensurate with the objectives. Coordination, accountability and reporting to stakeholders take time over and above the delivery of programme outputs and management of providers. Communication and coordination with all providers (in LHPP's case, over seven providers across four contracts) is essential and also very time-consuming. Recognising and resourcing these aspects of the work is vital to success.

The infrastructure, human resources and skills base to deliver a £1.3 million media/communications component and an impactful programme should not be underestimated. The advantage to councils of this 'in-house' approach is that there is no third party branding. Managing and coordinating the campaigns from the centre and synergising them with other programme components (condom distribution and outreach) to form a unified brand image means they are clearly seen by the public to be funded by the councils. Public health commissioning also retains control of the campaigns and can use its expertise to ensure synergistic messages with national and local initiatives.

In a complex area of public health such as HIV prevention, LAs will benefit from working with PHE and academic institutions which contribute the epidemiological and behavioural expertise required for sound evidence-based commissioning decisions, and which can also support evaluation.

London-wide activities such as the needs assessment for the LHPP offer added value through their on-going usefulness to individual LAs. Collaboration based on sound evidence will bring greater strategic influence and a stronger platform to link to national and local HIV prevention initiatives.

In collaborative work no assumptions can be made about consensus and delivery – time and effort are required to develop it. This can be done by presenting clear evidence for proposed actions, demonstrating value for money and ensuring evaluation mechanisms are in place.

“All London councils are working together on a sensitive, pressing issue. We can speak with one voice as a world city. We can look Berlin, San Francisco and Sydney in the eye and say we now have an HIV programme we can be proud of”

Paul Steinberg,
Lead Commissioner, LHPP.

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Cumbria and Lancashire Sexual Health Commissioners Network

Collaboration for improved sexual health

“No matter how much effort you put in, the network’s a really good approach – economies of scale, standardisation and mutual support”

Jackie Routledge,
Chair, Cumbria and Lancashire Sexual Health Commissioners Network.

“I am very mindful improving sexual health outcomes does not equate to having a service in place – behavioural change, attitudes, social norms must be addressed and local government does it very well”

Dr Sakthi Karunanithi,
Director of Public Health, Lancashire County Council.

Key messages

- A commissioners’ network can work productively and effectively on specific challenges including re-commissioning of sexual health services.
- Networks foster challenge, share skills and expertise and make effective use of scarce commissioning resources by minimising duplication.
- ‘Do once and share’ approaches require an investment in building solid relationships and trust which yield dividends to all parties in commissioning processes. For example, a single specification or a joint information day is beneficial to providers as well as to commissioners.

Outline

The Cumbria and Lancashire Sexual Health Commissioners Network (CLSHCN) covers four local authorities – Lancashire and Cumbria County Councils, Blackpool Council and Blackburn with Darwen Borough Council – spanning rural, coastal and urban areas of the North West. The network provides a valued forum for collaboration by the sexual health commissioners and public health departments in improving sexual health outcomes. In the run up to the transition of sexual health commissioning to local government, the network evolved from a wider membership. Its continuing role, value and focus as a commissioners’ forum were endorsed by the Directors of Public Health (DsPH) of the four local authorities following transition. As commissioning of public health services has become embedded in local government, the network has strengthened providing briefing on sexual health to health and wellbeing boards or other council committees such as cabinet. It is now working collaboratively in support of the re-commissioning of sexual health services across the area within a shared strategy and a consistent approach.

Context

Lancashire and Cumbria County Councils are two-tier and Blackpool and Blackburn with Darwen Councils unitary authorities. Population size differs between them: Blackburn with Darwen (147,369), Blackpool (141,400), Lancashire (1,180,076) and Cumbria (498,070).

The sexual health needs of the populations are diverse. Lancashire, a large county with a mix of towns, cities and urban areas, has

a large student population and four prisons. Cumbria has a sparse and dispersed population across a predominantly rural county, with some pockets of deprivation and large towns. Blackpool is the sixth most deprived local authority in England with a transient population including ten million 'pleasure seeking' visitors per annum and an established community of men who have sex with men (MSM). A third of Blackburn with Darwen's population is of South Asian heritage.

Within Lancashire and Cumbria, there are pockets of severe social and economic deprivation, including a high proportion of 'hidden' and long-term unemployed with low levels of basic skills. Seven Lancashire and Cumbria authorities (including Blackburn with Darwen, and Blackpool) are in the top 50 most deprived in England according to the Index of Multiple Deprivation 2010. Sexual health represents a significant proportion of expenditure from the overall Public Health ring-fenced grant, ranging from 8.6 per cent in Blackburn with Darwen, 14 per cent in Blackpool to 17 per cent in Lancashire. The network has developed a pan-Cumbria and Lancashire sexual health strategy with each constituent authority using this framework to develop its own local action plan. The plans take account of demography and sexual health indicators to develop locality-specific priorities.

As Dominic Harrison, DPH, Blackburn with Darwen Borough Council, states: "The sexual health status of communities is only partially determined by the presence or absence of effective sexual health services – important though they are. Effective programmes to promote good sexual health need to connect to the wider mobilisation of cultural, social and community efforts to promote wellbeing and positive mental health especially in children and young people. For these reasons, it is important sexual health services are collaboratively led by local government which already has the programmes, networks and relationships within communities to enable this. These wider capacities allow effective prevention and community based wellbeing

programmes to directly influence population sexual health outcomes."

The network

Objectives

The formal objectives of the CLSHCN are:

- to support integrated commissioning approaches
- to enable commissioners to share information, challenges, ideas and models of good practice and to support problem solving
- to facilitate commissioning of services
- to share information and intelligence on population needs and emerging issues
- to provide a confidential and safe forum to allow sharing of information from national bodies
- to work towards greater consistency of care standards and the development of appropriate specifications and commissioning policies, to enable integrated commissioning and services at a local level.

"The key is good relationships – an on-going dialogue – not being scared of difficult conversations – having those conversations then working towards answers and solutions, keeping the dialogue going and working through the implications"

Judith Mills, Public Health Specialist, Blackpool Council.

Approach

The CLSHCN meets bi-monthly in different locations and administration rotates. The underpinning philosophy is to 'do once and share'. It is chaired by Jackie Routledge, sexual health commissioner at Lancashire County Council and co-chair of the English Sexual Health Commissioners' Group. This strong link to the national commissioners' forum, which the network's commissioners also attend, is highly valued by network members and DsPH alike. It facilitates the flow of information to the network from national bodies and strengthens collaborative links with Public Health England whose local sexual health leads participate. The PHE local centre provides data, support and brokerage, for example linking the network to national initiatives such as the forthcoming procurement of HIV home sampling.

An important feature of the network is the strength of relationship, trust and loyalty between the sexual health commissioners who are all 'passionate about sexual health'. Commissioners value the network. As one explained: "There's a breadth of experience, a good dynamic when we meet. We all have the end user at the heart of what we want to do".

Members invest time and energy to welcome and include new commissioner colleagues. The network Chair mentored a new commissioner in a different authority, spending a day a week with her in the early days of her new role offering support and fostering her participation in the network. Developing this shared sense of responsibility and ownership for good outcomes in sexual health 'repaid the investment of time a hundredfold'.

"The network gives a framework for challenge across the system but also acknowledges the need to choose our own path"

Colin Cox, Director of Public Health, Cumbria County Council.

Challenges

Challenges for commissioners include prioritising collaborative cross-cutting activities in the context of a heavy workload. Network members report benefits are multiple, meetings well attended and ultimately time-saving through a single commissioner leading on specific issues and developing reports which their peers customise for local use. Each commissioner has a different background, strengths and experience and collectively 'the sum is greater than the parts'; drawing on individual skills reduces duplication of effort. Although respecting the individual processes of each local authority can lengthen decision-making and timetables, this collective focus can lead to stronger results through the sharing of expertise and standardisation of approaches.

Achievements

Achievements to date include development of a joint sexual health strategy across the network based on the priorities of 'A framework for sexual health improvement in England (DH 2013)'. As the 'Blackpool Sexual Health Action Plan 2013-2015' notes, "This plan recognises the priorities across Lancashire in addition to local needs and groups". Like the network it takes account of the need to ensure "seamless provision across boundaries" and to mirror the way sexual health services are used.

Exemplifying the 'do once and share' approach, where one local authority takes a lead on a particular issue and shares its work and findings across the network, is Blackpool Council's work on the integrated sexual health tariff. This was initially used in shadow form with the Blackpool provider and now the tariff has been introduced. Other local authorities are able to learn from this experience. Another example is the lead taken by one commissioner on understanding the Social Value Act, assessing its relevance to sexual health commissioning and disseminating the learning across the network. One commissioner explained: "I share everything

I've written and the others can use it. We localise the approach in our own areas".

The three Lancashire councils in the network have a co-ordinated approach to chlamydia screening including a single website and ordering system for their programmes. Good progress has been made, with Lancashire and Blackpool achieving detection rates of 3,892 and 2,292 respectively per 100,000 15-24 years old screened in 2013, better than the England average of 2,016 for this Public Health Outcomes Framework indicator. The three councils also coordinated an agreed plan for cervical screening to continue across the county in sexual health services. A single specification was developed for abortion services including provision of chlamydia screening and long-acting reversible contraception (LARC), with work on-going to include HIV screening in the future. Abortion rates are slowly continuing to fall, with the repeat abortion rate in under 25s below the England average of 26.9 per cent in the three Lancashire councils.

Two of the network's commissioners are currently providing advice to NHS England as it reviews pathways and models for the delivery of HIV care. This not only acknowledges the crossover between the local authority and NHS England in commissioning a pathway of services for HIV from prevention to treatment and care but also the credibility and expertise of the network's experienced commissioners.

The current focus of the network is on re-commissioning of sexual health services and commissioners have adopted a consistent approach through a shared prior information notice, a joint provider information day, development of common specifications (with some localisation), a common timetable for the award and commencement of services (with the exception of Cumbria CC), a joint communication plan ensuring consistent messages to stakeholders and a shared risks document. The advantages of this approach include consistency, economical use of scarce officer resources through task-sharing, attracting a wider pool of

potentially interested providers, sharing expertise by commissioners sitting on each other's evaluation of tender panels and greater transparency. As the commissioners share providers, the approach also prevents the destabilising of sexual health service provision. Each authority remains sovereign in its final decision-making and will award its own contracts. Although Cumbria is working to an accelerated timetable due to a local decision on procurement for a range of services, all other aspects are co-ordinated with the network. A commissioner from Lancashire will sit on the Cumbria evaluation panel.

Lessons learned

Each commissioner is responsible for cascading messages within their own local authority based on discussions in the network. Local authority processes take time and it is important to garner support upfront from councillors and other local stakeholders. Tailoring language and consistent messaging across stakeholders is vital in pre-empting issues and the network provides an important focus for achieving this.

The importance of the network for sharing responsibility and of open and honest communication to address difficult issues, such as the commissioning of cervical screening in sexual health services, is recognised by all members. The breadth of experience on the network facilitates mutual learning and support for new members. The network increases capacity and expertise; it also provides professional support.

A joint procurement process ensures transparency and fairness, with commissioners taking a consistent approach to each stage. This benefits both commissioners and providers through streamlined activities such as a single provider information day. It also reduces the effort of other council officers, such as legal, finance and procurement teams, generating a parallel network for them. The sexual health

network is well established and did not feel the need for a separate joint procurement process agreement, but recognises this might strengthen the approach to working jointly.

“It’s a good model for other areas of practice – it keeps a focus for expertise and the principles could be used for other areas of public health”

Dr Arif Rajpura, Director of Public Health, Blackpool Council.

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Commissioning integrated sexual health services in Leeds

Developing a new model in response to service user engagement

“Sexual health is one of our biggest commissioned services since public health returned to local authorities. I was keen to help shape the re-commissioned service in response to changing needs and to modernise”

Cllr Lisa Mulherin, Chair, Leeds Health and Wellbeing Board.

“Improving care and support for local people is the overriding concern, giving them choice. Commissioning is a driver to change and improvement – a very powerful lever”

Dr Ian Cameron, Director of Public Health, Leeds City Council.

Key messages

- Service user engagement is key to developing a model to meet the sexual health needs of the community and to ensuring their priorities and voice are incorporated at all stages of the commissioning process.
- The leadership role of councillors and the DPH is central in supporting engagement and effective communication with stakeholders.
- A partnership approach at all stages of the process pays dividends but commissioners and providers must

recognise that roles change during the formal tendering process.

- Applying project management methodology and expertise to the commissioning process and using dedicated resources manages risks and promotes effective and timely internal and external communications.
- Investment of time in the procurement process will be repaid through building a shared understanding of the model, changes and innovations required, and developing solid relationships on which to base delivery of the new service.

Outline

Before the transition of public health to local government, extensive service user research in Leeds had identified the need for an integrated approach to sexual health to improve access and create one stop services. Sexual health commissioners initiated early discussions with the procurement and legal departments of Leeds City Council (LCC) prior to transition. The council afforded high priority to public health and, within six months, the Executive Board approved a recommendation to tender for a new integrated sexual health service model, streamlining contracts with acute, community and primary care providers through a lead provider mechanism. A separate procurement process was approved for additional contracts for direct preventive work targeting those most at risk of sexual ill health. These HIV prevention and community testing services are delivered via the voluntary sector.

Strong relationships were built during the commissioning process for the new integrated

sexual health model with service users and providers; these are an important foundation for the mobilisation and implementation phases. The new integrated hub and spoke model delivered by an NHS and voluntary sector consortium goes live in July 2015 with primary healthcare providers being sub-contracted a year after commencement of the contract. This systems approach with clear clinical leadership for the city is designed to foster service innovation and increase self-care and self-empowerment by service users.

Context

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It has a large transient population including students at the city's three universities. Leeds is a diverse city with over 140 ethnic groups including black, Asian and other minority ethnic communities representing almost 19 per cent of the total population. There is a high demand for sexual health services in Leeds. Those most at risk of sexual ill health include men who have sex with men, young people, female sex workers and African communities.

The under 18 conception rate in Leeds for 2013 is 31.6 per 1,000 15-17 year olds and, although reducing, is higher than the England average of 24.3. The HIV diagnosed prevalence rate per 1,000 population aged 15-59 is 2.39, above the England average of 2.14. HIV late diagnosis is 47.3 per cent and although it has reduced from 51.6 per cent in 2010-12, it is still above the England average of 45 per cent. The gonorrhoea diagnosis rate of 67.2 per 100,000 is above the England average of 52.9. All new STI diagnoses (excluding chlamydia aged under 25) are 899 per 100,000 and above the England average of 832.

Commissioning an integrated sexual health service

Objectives

Sexual health services were re-commissioned to deliver the following benefits:

- a better experience for service users through a new integrated service model based on national best practice and the findings from local consultation with service users and communities at risk of sexual ill health
- better health outcomes through improved access for service users, providing early testing and treatment to stop onward transmission of STIs and prompt provision of contraception to reduce unplanned pregnancies
- better value for money through reducing duplication, realising efficiencies in order to invest to meet rising demand, and promoting preventive and risk reduction approaches.

• Approach

Approval for the procurement of sexual health services was given by the council's Executive Board. The Director of Public Health (DPH) was the delegated decision maker. A Sexual Health Project Board was established meeting monthly to oversee the process with representatives from a range of local authority departments including Children's, Adult Social Care, Environments and Neighbourhood, and Youth Services and from the Clinical Commissioning Groups (CCGs). The membership reflected the commitment to address wider issues and priorities, including child sexual exploitation and domestic violence and abuse, through the sexual health commissioning process. A Sexual Health Project Team met weekly coordinated by a project manager from the council's Public and Private Partnerships Unit (PPPU) (this unit manages the procurement and legal functions

of the Council). The Unit provided input from legal, financial and procurement specialists. The DPH and sexual health commissioners worked closely with the Chair of the Health and Wellbeing Board who received regular briefings, supported stakeholder engagement and met the successful provider.

Communication with counterpart commissioning colleagues outside the local authority was an important priority. Identifying 'go to' people and existing commissioner forums for proactive consultation at key stages in the process streamlined and improved communication.

The chosen procurement mechanism was the Negotiated Procedure which was considered the best match to deliver the complex service model and changes required. Key inputs from the procurement and legal departments supported the sexual health commissioners in making the best use of this procurement route. The role of the dedicated project manager was particularly valuable in managing risks and ensuring timely internal and external communication. There was extensive stakeholder engagement. Seven thousand people had responded to a service user questionnaire in 2011 and 2012 indicating a clear preference for an integrated model and improved access. Commissioners held a stakeholder event in partnership with other commissioners across West Yorkshire in the summer of 2013 to stimulate the market and to achieve early consultation on the concept of integrated sexual health and the emergent model with clinicians and potential providers. This event was attended by 130 people from across West Yorkshire. For commissioners this was a 'rich and creative event which opened the door to dialogue'. Clinicians raised important workforce training and development issues which were subsequently addressed in the service specification. There was further consultation with the market on the draft service specification through YORtender, the council's electronic tendering system.

Further extensive stakeholder engagement took place at key stages in the procurement process. This included focus groups with men

who have sex with men, African communities and young people before finalisation of the specification and during the final bids stage of the tendering process, with feedback to the evaluation panel. Holding small focus group discussions with communities most at risk from sexual ill health was the preferred route for community engagement at this stage as this 'sense checking' gave a wider view than could have been obtained from a representative panel member(s).

The service specification addresses key pathway issues including self-managed care and encourages improved productivity through the use of dual trained staff to provide contraceptive and HIV testing and STI services. Quality outcome indicators were used to set targets for increasing the number of dual trained staff in the first three years of the contract. The contract and service specification also incentivise the achievement of key performance indicators, notably on HIV testing and referral of HIV-positive individuals to HIV outpatient services. The role of clinical leadership across the integrated service in clinical governance, training and development, and innovation to develop the service model is highlighted in the service specification.

“The Negotiated Procedure is appropriate for a long contract and a complex service. It was the right decision for Leeds to use this mechanism. This process allowed tenderers to bring their models to life and allowed commissioners to sense check the proposed models against the service specification. It was a worthwhile investment of time to develop a shared understanding to get the service right for Leeds”

**Vicky Womack and Sharon Foster,
Sexual Health Commissioners.**

Following the award of the contract Leeds City Council was able to re-establish very quickly its longstanding working relationship with the incumbent providers. Meetings are held every two weeks to discuss mobilisation, check on progress and discuss risks and issues in the implementation of the new service model. The role of the sexual health commissioners prior to the start of the new service is to ensure services are mobilised as described in the tender. A joint communication plan is being developed by commissioners and the provider to ensure clear, concise and consistent messages about the new service. Liaison is with senior managers who are leading this phase of the project rather than the clinical leads. Commissioners are taking a supportive role in the mobilisation phase and, at the request of the Director of Public Health, will not be using sanctions if aspects of the service are not in place by the start date. Full service delivery will commence within six months of the 1 July contract start. Commissioners believe this approach has led to open communication from the providers on the problems encountered and a real sense of working together to address them.

“Re-commissioning is here to stay. I am keen to look further at how we use the Social Value Act in public health to ensure we are not driven solely by finance – another way to improve quality and approach the commissioning process”

**Dr Ian Cameron,
Director of Public Health.**

Challenges

The main challenge of the commissioning process was ensuring the tenderers' response matched LCC's ambitions in the service specification. This was addressed through the chosen procurement method which was a three-stage process - pre-qualification, initial bid and 'best and final

offer' (BAFO) stage. The BAFO stage was preceded by "negotiation meetings" which facilitated a dialogue between commissioners and providers. For commissioners these meetings were invaluable in 'bringing the model to life' and represented a 'worthwhile investment of time to develop a shared understanding'.

Retaining a good working relationship with incumbent providers was also a priority while observing procurement rules and procedures. Commissioners recognised the changing and formal nature of relationships during a tendering process and the need to step back. The DPH's role was central in leading strategic communication with all stakeholders, championing the vision for an integrated service. The advice of procurement specialists to ensure a fair, transparent and productive process was highly valued by the public health department for whom the process was a 'team effort'.

The importance of keeping a focus on improving care and support to local people – adding social value – as well as delivering efficiencies and better value for money was recognised by the DPH. Internal and external stakeholder engagement was time consuming, requiring inputs from the DPH, as leader of the commissioning processes, as well as from the sexual health commissioners. The DPH's role in managing different points of view, identifying and communicating risks at the right moment, also required an investment of time to ensure appropriate oversight of the commissioning process.

Finding premises in which to deliver a new service model was identified as a potential constraint. Commissioners took specialist estates advice as the availability of suitable premises was recognised as a challenge which could impact on mobilisation and implementation. Commissioners decided to specify locations for the hub and spokes rather than identifying specific premises.

In Leeds there was ultimately no need to transfer medical records to new providers, but this was flagged as a key 'risk' due to the central importance of the issue.

Achievements

A new service model has been successfully commissioned and mobilisation is under way. Positive feedback was received from bidders on the use of the Negotiated Procedure. Having a dedicated project manager kept the process on track and to time, identifying and managing risks and supporting on-going communication. Strong stakeholder engagement was achieved through focus group discussions at key stages including feedback on the service delivery models proposed by tenderers. Needs of specific populations were kept to the fore and addressed in the service specification and through on-going community engagement.

The winning bid was from a community NHS trust leading a consortium, 'Passionate about Sexual Health' (PASH), with an acute trust and voluntary sector provider. The service will manage the Leeds Chlamydia Screening Programme and, after one year, the consortium will also lead the sub-contracting with primary healthcare providers (GPs and pharmacies), developing a fully integrated sexual health service pathway. A lead provider and consortium delivery model streamlines the delivery process and commissioning relationships, facilitates and enhances partnership and fosters innovation through strong clinical leadership. The contract was awarded for five years with potential for three one-year extensions. This was commensurate with the time required to bring stability to the system and allow a new model to bed in, including increasing nurse-led services and expanding the opportunities for asymptomatic patients to self-test. The length of the contract also reflects the considerable investment of time in the process by commissioners and providers.

Lessons learned

The DPH, working with lead councillors, has a key role in setting the vision and communicating it to all stakeholders. The re-commissioning process is an opportunity to highlight and make the linkages to wider

council agendas, including child sexual exploitation and domestic violence, and to secure inputs from relevant council departments and portfolio holders. The Negotiated Procedure helped to get the pathways right to meet these needs as well as those of asymptomatic patients.

Strong service user involvement takes much time and effort but gives confidence to councillors on the direction taken. A coproduction process between commissioners, community groups and providers through the procurement approach was valued by stakeholders, laying the foundations for a partnership in mobilisation and implementation.

Procurement is a team effort and the role of the project manager was key in achieving a strong team approach. There is a need to familiarise and brief voluntary organisations on the procurement process to ensure their full participation. Workforce issues were covered in the service specification. The requirements of TUPE within local government contracts were potentially a new process for NHS bodies. Tenderers were advised to take their own legal advice.

To ensure clinical advice, the input of an external clinician is needed. In Leeds this was obtained from an out-of-area clinician, who contributed reviews of the tenderers' proposed service models. These were reported to the evaluation panel.

It is essential to document everything as the project can be challenged at all stages of the tendering process.

Creating opportunities to share learning with all public health colleagues is valuable to transfer the lessons learned to public health commissioning in other areas.

“The thing I am most proud of is our engagement with service users”

**Cllr Lisa Mulherin, Chair,
Leeds Health and Wellbeing Board.**

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Warwickshire's public health department leads collaboration to address young people's sexual health

“It's vital to work with head teachers, governors and the pupils themselves - that is the main part of the Respect Yourself programme. We also work with the council's community safety and drug and alcohol teams, the police and the police and crime commissioner”

Dr John Linnane, Director of Public Health, Warwickshire County Council.

“If you normalise the situation, if you have clear information, you can make better decisions - young people don't want to be lectured at”

Cllr Izzi Seccombe, Leader and Chair of the Health and Wellbeing Board, Warwickshire County Council.

Key messages

- Public health departments can collaborate effectively with community safety departments, education, youth services and the police to address young people's sexual health and wider issues of child sexual exploitation, consent and domestic abuse.
- Adopting a 'sex positive' approach to young people's sexual health requires careful planning and briefing of all stakeholders including councillors.

- Involving young people in designing social media to promote sexual health in their own language pays dividends and facilitates access to and use of sexual health services.

Outline

Warwickshire County Council pioneered the innovative 'Respect Yourself' (RY) programme to promote sexual health and wellbeing for 13-25 year olds. The programme is committed to giving young people the power to make confident, positive and informed decisions about their relationships and sexual health by building their knowledge and self-esteem. It has a website and a smartphone application developed through a series of residential workshops and training designed by and with young people. It also commissions training and provides data, analysis and other resources for organisations working with young people. Initially, the RY programme was developed in partnership with the NHS by a sexual health commissioner jointly employed by local government and the NHS prior to the transfer of public health.

Since the transfer, partnerships have also developed with the children's and community safety departments, the council's lead officers on domestic abuse and substance misuse, the police and crime commissioner, and the police. The programme works closely with primary and secondary school governors, head teachers and staff as well as pupils. The RY programme has the support of the council's leader and chair of the Health and Wellbeing Board and the portfolio lead for health, both of whom are fully briefed by the public health department on the often

sensitive topics to be covered.

The website and smartphone application have been evaluated by Coventry University and their role in increasing service access at GUM sites in the most deprived parts of Warwickshire has been cited as an example in Department of Health guidance to health visitors and school nurses. Feedback from young people using the site and attending the residential workshops has been used by the sexual health commissioner in needs assessment for the redesign of sexual health services.

Context

Warwickshire is a mixed urban and rural county with a total population of 545,500 people. 12 per cent are from black and minority ethnic groups. 22.6 per cent of the population are aged 0-19 years and 24 per cent 20-39 years. The under 18 conception rate for Warwickshire in 2013 was 23.4 conceptions per thousand women aged 15-17, lower than the England average of 24.3. The estimated number of conceptions to women under 16 was 41 in 2013 compared to 43 in 2012. Access to and uptake of sexual health services is variable across the county. The chlamydia detection rate of 1,535 per 100,000 aged 15-24 years is below the England average (2,016) and the target rate of 2,300. 29.4 per cent of abortions in under-25 year olds are repeat compared to the England average of 24.3 per cent.

“You have to trust young people to know what they need and go with that”

Etty Martin, Sexual Health Commissioner, Warwickshire County Council.

The Respect Yourself programme

Objectives

The RY programme is committed to giving young people aged 13-25 years old the power to make confident, positive and informed decisions about their relationships and sexual health by building their knowledge and self-esteem. It aims to reduce the number of teenage pregnancies and improve young people's sexual health and wellbeing.

Approach

Warwickshire County Council's sexual health commissioner and RY team are based in the public health department within the communities' directorate. They work with departments across the local authority, schools and colleges, and health and voluntary organisations across the county. The RY team's approach includes:

- commissioning projects, including the RY website and application, using comprehensive needs analysis that applies local and national data, research, guidance, evaluations and consultations, to improve the health and wellbeing of young people in Warwickshire
- offering information, support, resources and advice relating to relationships and sexual health to all organisations working with children, young people and families, as well as for individual cases, services or local areas
- coordinating and developing countywide sexual health training for clinical and non-clinical professionals
- providing up-to-date statistics, needs analysis and mapping of current impact, interventions and service provision
- holding a robust evidence base of commissioned project work including consultations and research with young people.

The RY website and application were created by the joint NHS and local authority sexual health commissioner and the RY team in the run-up to the transfer of public health to local government. It drew on the Dutch 'sex positive' approach to young people's sexual health following a study tour to the Netherlands by the RY team and 20 frontline workers. A post-tour conference shared the message and approach with senior managers across the local authority and the NHS, gaining their endorsement and addressing concerns about its potentially controversial nature. The chair of the health and wellbeing board supported the approach through a conference welcome video. The conference anticipated how to deal with possible bad publicity through the use of a 'Have I got news for you' session. The RY team then set about redesigning the way the council communicated with young people on sexual health through its RY website. Prior to the launch of the refreshed RY website, briefing was provided to councillors and senior managers in local government and health through meetings at which the evidence base for the approach was presented and their questions answered.

From the start of the programme, the RY team worked through its partnership with schools and young people. Its approach and materials are co-produced and co-designed. Young people worked with the RY team to develop the service specification, meet potential site developers and decide which contractor would be commissioned to undertake the work. The website provides information about contraception, STIs, relationships, sex and bodies, and a service finder. Using a comprehensive 'sex positive' approach, it enables young people to ask questions about issues that directly affect them. It also has a page for parents requested by the young people themselves.

A smartphone application allows access to the service finder which includes the ability to rate the experience of attending a particular clinic or service. This can be done on site using a QR code. An evaluation of the impact of the application in changing

behaviour and increasing the uptake of sexual health services across Warwickshire was commissioned from Coventry University.

Annual residential workshops for young people have developed the website's contents to tackle such subjects as sex and the law, abusive teenage relationships, child sexual exploitation and online safety. A range of online games and quizzes are used on the website resulting from workshops which also feed into the development of teaching materials. Examples include a 'relationship health checker'. This is an online questionnaire that encourages young people to explore their relationships and check for possible signs of trouble. The checker signposts respondents to advice and support.

Sexual coercion, abuse or assault were also addressed through a 'Yes, No Game' consent competition. Young people were invited to develop promotional adverts to highlight issues around consent. As of April 2015 there had been over 7,500 views of this page.

Focussed originally on reducing teenage conceptions and improving the sexual health and wellbeing of young people, the RY work has expanded to include issues of child sexual exploitation and online safety through working closely with local authority colleagues leading on domestic abuse and sexual violence. The sexual health commissioner works in collaboration with the community safety department, also located in the communities' directorate, on its sister website 'Urdecision'. This covers issues such as boundaries, abuse, sexting and grooming. Videos shot with professional actors are used to address these issues to which there are links on the RY website. The public health department also collaborates with the police and crime commissioner who contributed funding to the RY website and 'Urdecision' to add new features addressing pornography, consent, child sexual exploitation and domestic abuse.

Challenges

Initially, the challenge was moving from a 'sex negative' to a 'sex positive' approach to disseminate sexual health messages to young people based on the Dutch model. This advocated using honest, factual and humorous language in answers to young people's concerns and questions. Preparatory work, such as a conference and briefing for senior managers and councillors, were required prior to launching the website and smartphone application to explain the approach and gain the endorsement of stakeholders. It was also necessary to explain the rationale to schools including governors and parents.

Ensuring the website was based on young people's needs, used their language and was presented through relevant media such as videos, quizzes and FAQs was an early design challenge. This was achieved through residential workshops and a young person's programme board.

Despite the support of head teachers, parents and governors and an experienced sex education consultant, the website still raised controversy in the media. Portfolio holders for children's services and public health and the shadow health and wellbeing board chair had been fully briefed on this new approach to the sexual health and emotional wellbeing of young people. The council remained supportive of the underpinning 'sex positive' philosophy despite the media headlines. The RY team anticipated and planned for this initial backlash. Consideration was given to a proactive approach but it was concluded that press releases heralding the website as 'good news for young people' would still have led to critical coverage in some media outlets. It was also noteworthy that public comment on any adverse coverage was mainly supportive. The negative media coverage evaporated in the face of this supportive public feedback.

Remaining vigilant and aware of information governance issues and keeping young people safe and secure while dealing with sexual health is an on-going challenge.

The website is endorsed by the UK Safer Internet Centre.

Achievements

The website has gathered momentum and its use has increased from 600 to 40,000 hits a month with wide knowledge of the site amongst Warwickshire's young people.

The work on sexual health for young people is embedded in the council. It has the full support of councillors and senior managers as well as continuing and developing links to health through the CCG, with the police and wider community organisations.

The evaluation of the website and the smartphone application by Coventry University using a behaviour change model showed an increase in the use of sexual health services at 'two of the more deprived GUM locations' by young men who are a key target group for the RY programme.

Although initially linked to addressing teenage pregnancy and sexual health and wellbeing, the 'sex positive' approach and the website development laid the foundations for public health inputs to wider issues of child sexual exploitation and consent. The competition and videos on consent are a good example of the linkages forged to wider council priorities. Locating the public health department in the communities' directorate, and the credibility it developed by championing the 'sex positive' approach, have been instrumental in its wider involvement in community safety issues.

The RY team anticipated the potential for bad publicity and planned for this from the beginning. This approach paid off and senior stakeholders remained supportive in the face of opposition to the website in the media. Latterly, the RY website has also received positive media coverage. It was described in the Guardian in 2014 as "one of the more interesting attempts to demystify sex for young people (...) dispenses chatty, informative and non-judgemental advice".

Teenage pregnancy data is closely monitored by the RY team. The trend for Warwickshire

continues downward and the teenage conception rate is below the England average. Use of the website is rising and the type of questions young people ask increasingly demonstrate they are taking responsibility for their sexual health and wellbeing.

Lessons learned

For the director of public health (DPH) “the biggest lesson learned is that this approach to addressing young people’s sexual health needs, although challenging, works”. Involving pupils, teachers, parents and governors from the beginning is essential although it can be difficult. “It is necessary to be open and upfront, it cannot be tacked on to other things”.

When briefing councillors in leadership roles, it is important to give the evidence base, facts and evaluation findings and to be well prepared. Planning ahead for potential adverse media coverage will be beneficial.

It is vital to answer all questions asked online and to produce credible FAQs in language relevant and accessible to young people. The lesson the DPH and team have learned is “young people are responsible and trustworthy and can deal with it”. They also found, when it came to using the language young people requested on the website, that following careful briefing, “the portfolio holders for health and wellbeing and public health were right behind us – very supportive”.

There is a need to renew the work continually and to be responsive as it develops. A new cohort of young people is coming up and it is vital to re-engage and produce something they will use and value.

“The RY programme has influenced our work on children and young people and working with schools. We will take the learning into the redesign of school nursing”

Dr John Linnane, Director of Public Health, Warwickshire County Council.

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A joint commissioning team and public health colleagues work to improve sexual health in Lambeth, Southwark and Lewisham

“As lead member on public health, balancing priorities, I have to look at whether spending could be better used by enabling more prevention”

Cllr Barrie Hargrove, Cabinet member, public health, parks and leisure, London Borough of Southwark.

“It’s the best value to work together, there are shared needs across the boroughs, people aren’t restricted by boundaries and we have to respond to needs”

Andrew Billington, Lead Commissioner, Sexual Health and HIV, London Boroughs of Lambeth, Southwark and Lewisham.

Key messages

- Sharing commissioning and public health expertise as well as back office functions across three boroughs is resource efficient and increases capacity, reducing duplication and freeing up time to focus on strategic priorities.
- Shifting the balance of resources between clinical services and prevention requires a strategic approach to modernisation of services, innovation and strong working relationships between councillors, commissioners, public health and wider partners.

- Transformation and modernisation require boroughs to work simultaneously on a local and a London-wide basis in recognition of rising demand, patient flows in an open access system and patterns of service provision. The tri-borough structure facilitates higher visibility and leverage for Lambeth, Southwark and Lewisham.

Outline

The London boroughs of Lambeth, Southwark and Lewisham (LSL) have high rates of sexually transmitted infections, HIV and teenage conceptions. The three boroughs have a history of collaboration on sexual health. They agreed to commission sexual health services through a tri-borough sexual health commissioning team working in close partnership with the public health departments when these transferred to local government. Lambeth council hosts the commissioning team with the three boroughs remaining responsible for approving their expenditure on sexual health services through the ring-fenced public health grant. Lambeth and Southwark councils have a joint public health team. The tri-borough team also has strategic commissioning oversight of termination of pregnancy, vasectomy and HIV care and support services on behalf of the three local clinical commissioning groups (CCGs), lessening potential fragmentation.

The tri-borough commissioning and public health teams worked closely with their partners to develop a sexual health strategy for 2014-2017. The strategy outlines the many challenges facing the boroughs to improve sexual health outcomes for the priority groups identified who are men who have sex

with men (MSM), young people and Black African communities. The key objectives of the strategy are to improve sexual health outcomes and to modernise and reshape sexual health services, shifting non-complex activity to self-management, pharmacy and primary care. The boroughs recognise the need to support innovation including the use of new technologies. One example is SH24 which has been developed to provide an online sexual health service in response to high levels of sexual ill health in Lambeth and Southwark. It provides free and confidential STI testing accessible 24 hours a day for chlamydia, gonorrhoea, syphilis and HIV.

Strong public health leadership and inputs to both strategy development and implementation have been essential to developing effective sexual health commissioning in LSL. Economies of scale are achieved through a tri-borough team as well as sharing scarce resources and expertise across the boroughs. Given the high levels of sexual health need in LSL and rising demand within local authority finite resources, the commissioning and public health teams are also centrally involved in broader collaborative approaches to tackling sexual health priorities and reshaping services across London, as described in the case study on page 52.

Context

LSL have a combined total of 880,620 residents (Lambeth: 303,100; Southwark: 288,283 and Lewisham 284,000 people). All three boroughs have young and ethnically diverse populations. MSM in Lambeth and Southwark are estimated to be 15 per cent of the total population – the highest estimated concentration of MSM in London and the UK. The boroughs are also home to other groups with disproportionate levels of sexual ill health and needs, including migrants from countries with relatively high HIV prevalence, refugees and asylum seekers, and homeless people.

In 2013, Lambeth had the highest rate of acute STIs diagnosed per 100,000 residents

in England at 3,269, including the highest rates of syphilis and gonorrhoea. Southwark and Lewisham also had STI diagnosis rates well above the England average of 832, at 2,516 and 1,168 respectively. Lambeth's HIV prevalence is 14.70 per 1,000 population aged 15-59 years, the highest in England. Southwark's HIV prevalence is 12.63 which is the second highest, and Lewisham's 8.18 which is the sixth highest, in England. Lambeth and Southwark have rates of late diagnosis of HIV which are better, at 34.7 per cent and 38.7 per cent respectively, than the London and England averages of 40.5 per cent and 45 per cent, although Lewisham's is just above both averages at 46.1 per cent.

LSL have higher than average teenage conception rates compared to London and England, but significant progress has been made in reducing these over the last 15 years. Lewisham's rate is the highest at 33.1 per 100,000 under 18's compared to a London average of 21.8 and an England average of 24.3 in 2013. Rates of GP prescribed long acting reversible contraception (LARC) are below the average in Southwark and Lewisham at 19.6 and 18.0 per 1,000 compared to a London average of 25.1 and an England average of 52.7. Levels of repeat abortion for under 25s are above the London average of 32.6 per cent in both Lewisham at 36.9 percent and Southwark at 34.2 per cent and slightly below in Lambeth at 31.9 per cent.

In LSL, £29.17 million (97.5 per cent of total expenditure on sexual health) was allocated to clinical services and £0.75 million (2.5 per cent) to HIV prevention and sexual health promotion in 2013/14. LSL's strategy recognises this is poorly aligned with its strategic intentions for 2014-2017 which are 'to promote sexual wellbeing and prevent sexual ill health'. The focus of its action plan is therefore 'to shift investment into evidence-based prevention' and 'to explore a range of alternative service models, including online services and other technical innovations'.

Tri-borough sexual health commissioning

Objectives

The objectives of the tri-borough commissioning team are to:

- improve sexual health outcomes in an area of high need
- offer a choice of services and achieve better value for money from available resources
- maintain strategic oversight of sexual health commissioning, including abortion services, to address potential fragmentation in the post-Health and Social Care Act commissioning landscape
- achieve economies of scale and share learning and practice across the boroughs which, despite some marked differences, all have high levels of need
- utilise the opportunities to link with other health and social care commissioners to deliver more targeted support to priority groups and vulnerable populations including people with problematic substance use, homeless people and vulnerable young people
- increase leverage and improve visibility in pan London work to modernise and transform sexual health services.

Approach

The sexual health commissioning team, managed by an assistant director of commissioning, has a lead commissioner, two senior commissioning managers (one for sexual health promotion and HIV prevention and the second for young people, HIV care and support, and abortion services), a performance manager, finance officer and contracts manager. The tri-borough team's strategic commissioning oversight on behalf of the three local clinical commissioning groups (CCGs) led by the second senior

commissioning manager facilitates integrated care pathways for sexual and reproductive health. There is also a primary care commissioning post across all public health commissioning including sexual health, and an innovative joint young people's commissioning post across sexual health and children and young people's services. There are public health consultants leading on sexual health for each of the boroughs who also take the lead on specific sexual health issues and advise on these across the boroughs. This approach is resource efficient, avoiding duplication and providing the benefit of complementary expertise.

The commissioning team reports to a sexual health board on which the CCGs sit with the local authority commissioning and public health departments. This has oversight of the budget. The team also reports to the three borough-based health and wellbeing boards where the sexual health strategy was approved.

LSL are also a key stakeholder in the London Sexual Health Services Transformation Project and represented on all its sub-groups, with the lead commissioner contributing to one of the work streams. It is also part of the collaborative commissioning of GUM services. These are described in the case study on page 52 and are complementary to LSL's local strategic priorities: to reshape and modernise services, achieve cost efficiencies to meet rising demand and rebalance expenditure between clinical services and prevention. Engagement in wider London work also recognises that use of out of borough GUM services is high, particularly for Lambeth residents.

The LSL sexual health strategy for 2014-2017 was developed in partnership with the local CCGs, acute NHS trusts, community, primary and third sector providers and service users. Feedback was invited via the Lambeth Council website with links from all LSL CCGs and council websites. Following a launch event, nine focus groups were held in LSL (three in each borough) with MSM, young people and Black African people.

Feedback was received from primary care networks, Local Medical Committees (LMCs), Local Pharmacy Committees (LPCs), scrutiny committees, Healthwatch, voluntary sector organisations, local NHS providers and children and young people's services.

Following approval of the strategy, a sexual health action plan was agreed to manage implementation. Key priorities have been taken forward in year one. These include commissioning LSL-wide sexual health promotion targeted at Black African communities and MSM, reviews to create more cost-effective sexual health provision in general practice and community pharmacy, and review of the sexual health model to align it with both the sexual health promotion programme and the outcome of the primary care reviews.

The sexual health promotion programme includes HIV prevention, LSL-wide condom distribution, promoting access to HIV testing and initiatives to address substance use eg 'chemsex'. It prioritises the most vulnerable people in identified priority groups. It will be aligned with the work of the London HIV Prevention Programme by, for example, expanding HIV testing in wider community settings including pharmacies, health checks and other non-clinical settings.

The review of sexual health provision in general practice and community pharmacy is part of the strategy to develop a new model of sexual health provision with increased self-management and access to services closer to home, particularly in areas of high deprivation and need. Identifying the best pattern of services across general practice and community pharmacy, and the training and incentives required to deliver wider access to sexual health services, are strategic priorities working with the new GP federations, LMCs and LPCs.

An innovative feature of the approach to modernising sexual health services has been the development of SH24. This virtual sexual health service, providing free and confidential STI testing accessible 24 hours a day for chlamydia, gonorrhoea, syphilis

and HIV, recognises the role of technology in empowering service users and improving efficiency and access through self-management. Supported through charitable sources and delivered by a community interest company, this web-based service was developed by the public health team at Lambeth and Southwark working with specialist sexual health services, sexual health commissioners and the Design Council. The service went live in March 2015 after extensive engagement to design its first minimal viable product, offering the most basic yet most important functions to users, based on the principles of the Government Digital Service. A review is planned in the final year of the strategy to develop an onward plan for commissioning of SH24. It could be scaled up to include Lewisham and also to cover geographical areas outside LSL in the future.

“Public health consultant input is critical. The commissioning hub alone without public health support would be very different. It's a strength that commissioners and public health work closely together”

Ruth Hutt, Consultant in Public Health, London Borough of Lewisham.

Challenges

The biggest challenge for the modernisation of sexual health services in the areas of highest need is increasing the focus on prevention. This requires working simultaneously in support of London-wide transformation of open access services using the increased leverage and visibility of the tri-borough approach and addressing LSL's strategic objective to 'embed good sexual health and wellness as part of a wider health agenda' for local priority groups. 50 per cent of service use by Lambeth residents is outside the borough – principally north of the river – and there are also significant inflows of patients to services in LSL. This is not unusual

for a local authority-commissioned service in London and achieving a balance between London-wide collaborative work, including GUM commissioning, and local work is an on-going challenge for the commissioning team.

A focus on young people is required, to continue to reduce the rate not only of teenage conceptions but also of STIs and to respond to emergent needs such as addressing sexual violence. As one of the public health consultants observed “the challenge is how to improve young people’s sexual health without being paternalistic and to focus on the most vulnerable”. The commissioning team and public health lead for young people are reviewing current young people’s services and joining up commissioning priorities with colleagues in children and young people’s services through the joint commissioning post.

Lambeth has the largest number of people living with HIV in a single borough, in London and England. HIV is now a long term condition (LTC) and this presents a huge challenge to the commissioning team which is responsible for both HIV prevention and strategic commissioning of care and support on behalf of the CCGs which also have an important role in managing HIV as an LTC. Following a review, a new service model was recommended for care and support with an increased focus on self-management and use of mainstream services where those services can meet the needs of people with HIV. The commissioning team is working to ensure user engagement in implementing this approach through the Service User Reference Group.

The workload to develop the strategy was considerable and the role of the assistant director of commissioning in providing leadership was vital. The boroughs have different business processes which can be a challenge for commissioners especially if there is staff turnover in key roles within or relating to the team. The three CCGs also operate differently and they are a key stakeholder for the sexual health commissioning team, so investing in maintaining good working relationships is important.

Finance presents a number of challenges, including matching rising needs to the budget allocated for sexual health and shifting the balance between clinical services and prevention in an environment where public health allocation no longer benefits from the annual uplifts it would do if still held within the NHS. Political engagement in this process is important. Commissioners and public health departments have an important role in informing the process through an evidence base of demography, epidemiology, activity and financial data. These can demonstrate where services can become more efficient or effective but also explain where and why a rise in disease rates recorded may be evidence of success - at least in the short term. Some funding is pooled and some is held locally and this can lead to challenges in reconciliation. As money gets even tighter, ensuring the correct attribution will become ever more vital.

“LSL are taking a role in London transformation. Together we are stronger as we account for a large part of the activity and 24 per cent of people living with HIV in London are from our boroughs, so we are a significant stakeholder”

Ruth Hutt, Consultant in Public Health, London Borough of Lewisham.

Achievements

The development of a tri-borough sexual health strategy and action plan was an achievement for the commissioning and public health teams. There was a high level of stakeholder engagement in development of the strategy which was also successfully steered through the three boroughs’ business processes. The oversight of the assistant director of commissioning was important in achieving this.

Joint work on all aspects of the commissioning cycle will continue. As well as bringing technical expertise, the public health teams have 'held the organisational memory'. Commissioners and public health have worked together on aligning key performance indicators and sexual health outcomes.

Validation of sexual health service activity data has been undertaken for all three boroughs by a single officer. In the future this will be undertaken by NE London Commissioning Support Unit. This allows concentration of expertise in a vital role which generates savings across the boroughs and could not be replicated in all three.

Lessons learned

Setting up a tri-borough approach has increased capacity by having people lead on specific areas. For example, the public health teams not only have knowledge of their own borough(s) but also lead on specific issues. This is helpful when producing reports as they can be generated once and used in all three boroughs. A recent example was a report to councillors on the 'Halve it' campaign to reduce late diagnosis of HIV.

Combining back office functions sooner, especially data validation, would have paid dividends. Such functions were originally performed locally but concentrating expertise in a single tri-borough role as part of the commissioning team has produced savings through more efficient and effective contract management.

It is important to communicate outwards as well as inwards particularly when reviewing services. Working with the LMCs and LPCs on the primary care review, for example, gave a better understanding of where investment would be required if primary care were to play a larger role and led to the development of a training plan for GPs and community pharmacies. There was also a need to reinvigorate stakeholder engagement with the voluntary sector through the community forums which had lost momentum during transition.

“We want to normalise and destigmatise sexual health and embed it in everyday life, like getting a parking permit, by increasing access to testing online”

Dr Gillian Holdsworth, Consultant in Public Health, London Boroughs of Lambeth and Southwark.

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Birmingham and Solihull sexual health treatment and prevention services

Two local authorities collaborate to commission redesigned services

“Stephen Munday and I shared the role of setting the direction of travel, driving the system change, explaining why and getting the narrative clear”

Dr Adrian Phillips, Director of Public Health, Birmingham City Council.

“The whole procurement process was supported and challenged by a Procurement Board. Procurement expertise has been really important. We were required to go to a Cabinet member for a final decision about the specification and going to tender”

Dr Stephen Munday, Director of Public Health, Solihull Metropolitan Borough Council.

Key messages

- Keeping a focus on sexual health outcomes and a clear vision are the foundation of a successful commissioning and re-procurement strategy.
- Building and delivering a consistent narrative on the vision and direction of travel for sexual health services at all market and stakeholder events is essential.
- Councillor engagement at all stages of the commissioning process supports addressing wider Council agendas,

delivering key messages and keeping a focus on evidence, outcomes and value for money.

- Local authorities can facilitate the involvement of young people in needs assessment and the tendering process, challenging the status quo for commissioners and providers alike and shaping future services.
- Competitive Dialogue is well matched to developing new models of care and delivery, and strong commissioner/provider relationships provide a foundation for future innovation.

Outline

Birmingham City Council (BCC) and Solihull Metropolitan Borough Council (SMBC) collaborated on the commissioning of integrated sexual health treatment and prevention services. Prior to transition, based on a detailed needs assessment, the sexual health strategy had supported the development of integrated services. These had been piloted but not fully implemented. The local authorities were committed to re-commissioning and service re-design. The councils agreed to a joint commissioning process for integrated sexual health services with Birmingham City Council also commissioning services in primary healthcare. Contracts were simultaneously awarded based on a common specification for mandatory services. There were differences between the two authorities' contracts in relation to the role of the lead contractor sub-contracting GPs and pharmacies, and the extent of non-mandatory non-clinical health promotion and outreach.

The re-commissioning's key objectives were to develop an integrated and better coordinated sexual health system operating seamlessly across the two boroughs, and to stimulate a step change regarding the approach to sexual violence and exploitation as well as to services in primary care. Another objective was to reduce the number of contracts, freeing commissioners from a primary focus on contract management in favour of achieving improved sexual health outcomes. The high number of contracts (21) was a legacy of commissioning across three primary care trusts. The new commissioning model prioritised improving services, addressing structural inequalities and inefficiencies and achieving improved outcomes. The service specifications for mandated and non-mandated services were outcome focussed rather than output driven. In addition to the three Public Health Outcomes Framework (PHOF) priorities for sexual health, seven locally identified outcomes were developed. Commissioners held three well-attended market days and fostered significant stakeholder engagement. Working with a young persons' panel to contribute to the tendering process was for one BCC public health consultant "a career highlight".

Context

Birmingham City Council is the largest local authority in Europe with a population of 1.1 million. It has the youngest population of any city in Europe with 45.6 per cent of residents being under 30. Solihull is a Metropolitan Borough Council to the south east of Birmingham with a population of 206,000 people of whom 36.8 per cent are under 30. Genitourinary medicine services in Birmingham are used by Solihull residents. The proportion of people aged 15-44 years is set to grow further in Birmingham meaning demand for sexual health services will increase.

The number of new STI diagnoses increased by 30 per cent in Birmingham GUM clinics between 2008 and 2012. In the light of overall population growth more people will

be presenting to sexual health services in the coming years. Chlamydia detection rates per 100,000 population aged 15-24 years are above the England 2013 average of 2,016 in Birmingham at 2,167 but below the average at 1,561 in Solihull. In Birmingham, the gonorrhoea diagnosis rate of 89.5 per 100,000 is above the England average of 52.9.

Although good progress has been made on PHOF indicators, there are variations across the city. Public Health England Sexual and Reproductive Health Profile data for 2013 highlight that Birmingham still has a prevalence of under-18 conceptions higher than the national average – 25.9 conceptions per 1,000 15-17 year olds compared to an England average of 24.3. Teenage conception rates vary significantly by ward. Rates of repeat abortions in under-25s in Birmingham (30.2 per cent) are higher than the England average (26.9 per cent) for 2013.

Birmingham has the second highest number of people living with HIV outside London (1542 people in 2013 with a diagnosed HIV prevalence of 2.54 per 1,000 population aged 15-59 years). Although the late diagnosis rate declined to 48.3 per cent in 2013, it is above the England average (45 per cent).

Commissioning integrated sexual health services

Objectives

The commissioning objectives were:

- to develop service specifications on an outcomes basis for mandated and non-mandated services and improve sexual health outcomes
- to develop a coherent integrated sexual health system within an improved infrastructure, offering a good patient experience
- to provide improved support for people vulnerable to, and victims of, sexual

coercion, sexual violence and exploitation to reduce the number of contracts for sexual health services by letting the contract to a single lead provider working with a range of partners, including primary care, within a formalised partnership arrangement.

In Birmingham the sexual health system included GPs and pharmacies although Solihull decided to retain separate commissioning of its primary care services.

“Aligning the sexual health agenda with other council agendas in a single system was positive, for example, addressing sexual coercion and seizing a real opportunity to link to our Safeguarding Plan for children”

Cllr John Cotton, Cabinet Member for Health and Wellbeing, Birmingham City Council.

Approach

The public health departments recognised the delivery of a new service model would require stakeholder engagement and market stimulation due to the restricted nature of the market. An independent organisation was used to undertake consultation with priority groups through a questionnaire generating over 3000 responses as well as focus group discussions.

‘The Birmingham and Solihull Sexual Health System’ event, the first of three market days, was attended by 150 organisations. The aim was to introduce potential providers and other interested parties to the plans for a new sexual health system. Two councillors, the public health teams, BCC procurement department, a young people’s representative, clinicians and the CCG chair contributed to the event. Each responded in their presentations to the question ‘What do we want the market to deliver through this procurement?’ developing a rich picture for delegates of the objectives of procurement from the perspective of different stakeholders.

The second and third market days used a co-production model to address two topics. The first was ‘Sexual coercion, exploitation and violence and the sexual health system’. The aims of the event were to bring prospective providers together, to brief them on the issue of Violence Against Women and Children (VAWC) and, through participant exercises, to improve the sexual health performance framework and service specification in relation to VAWC. Two councillors, the BCC public health team, children’s services, local young people’s voluntary organisations and the Sexual Assault Referral Centre contributed to the event. It signalled the ‘game changing’ opportunity of re-commissioning to address these issues in the new sexual health system.

The second topic was ‘Maximising the role of primary care in the new sexual health system’. Speakers including a councillor, the public health team, the Local Medical Committee and a pharmacist contributed to the event. A workshop session for participants addressed the question ‘How can functions delivered through primary care contribute to outcomes?’ For Birmingham’s Director of Public Health (DPH) who spoke at each event, bringing potential providers together in this way was ‘doing something different’. The events developed the narrative that ‘this was not just a re-procurement but building a single system, with a greater focus on the broader impact of child sexual exploitation and other priorities such as safeguarding vulnerable populations’.

A Sexual Health Strategic Commissioning Group developed the new sexual health approach based on needs assessment, the market days and stakeholder engagement. Membership of the group included the two local authority public health departments, CCGs, Public Health England, NHS England, BCC children’s commissioning team, the Local Pharmaceutical Committee and a range of third sector groups. The approach had the following elements:

- a single system approach – all aspects of provision contained in one contract
- more use of family doctors (GPs) and community pharmacists

- better links between third sector organisations and NHS services
- less variation in service costs, quality and performance.

Ten outcomes became the foundation of the performance management framework in the service specifications co-produced with the existing providers and other local authority departments. Three outcomes were taken from the PHOF. Engagement with service users led to the development of the other seven including additional areas for sexual health improvement, identification of and improved support for people vulnerable to, and victims of, sexual coercion, sexual violence and exploitation, and better access to services for high risk communities.

Competitive Dialogue was chosen as the procurement route. There were 13 expressions of interest leading to three organisations responding to the invitation to tender. Following a pre-qualifying stage, there was an initial evaluation of the tenderers' proposals and feedback to the tenderers followed by four dialogue sessions covering:

- how to maximise the role of primary care
- tackling sexual coercion
- the financial framework
- contractual terms and conditions.

Best and final offers were submitted and evaluated in respect of comparative quality (40 per cent), social value (10 per cent) and price (50 per cent). The evaluation panel included public health, commissioners and finance officers from both local authorities supported by BBC's corporate procurement services. An external team of three clinical experts in sexual health were consulted during the evaluation of tenders and gave their advice through the chair of the panel. Specialist advice was also given by PHE and an expert in safeguarding including sexual coercion, sexual violence and exploitation.

Another key part of the evaluation process was feedback from a 63 member young persons' panel. Their inputs were achieved

through a two-day workshop, the first day outlining the issues so the young people could interrogate the offer and the second day with providers doing presentations on the service model. The power, maturity and insight of the young people's contributions was appreciated by the commissioning team. Members of the panel relished the opportunity offered to 'shape and stimulate'. As one young participant put it, "Testing facilities don't matter to me, what matters is, is it going to be confidential?"

The contract was awarded to an NHS Foundation Trust as the lead provider sub-contracting and managing other organisations, including the third sector and primary care (Birmingham only), to provide services through a strong integrated governance model. The new service is to be known as 'Umbrella' in recognition of its integrated approach and partnership delivery model.

The two local authorities have built on the foundations laid in the commissioning and procurement processes to develop key principles for the mobilisation phase. These are co-production, risk-sharing and making the best use of resources. A partnership board has been established between the local authority and the lead contractor. There is also an operational mobilisation group on which the commissioners and lead officers for the providers sit. In addition, the local authorities have continued to meet regularly face to face with the 'exiting' provider.

A mobilisation plan was included in the tender. Developing and taking forward this detailed plan is the framework for the mobilisation board and group's work. Commissioners have had to balance risks identified. Some aspects of service delivery must be available as of day one of the new contract eg mandatory clinical services. Other aspects are part of a three to five year developmental plan and cannot be expected from day one; however, clear milestones have been set by commissioners to monitor progress. Recognising the importance of data

and metrics in monitoring the development of the service, a PHE scientist will be located at 'Umbrella' to work with the provider to track trajectories and changes over time with particular emphasis on addressing inequalities (eg in levels of LARC fitting in different parts of the city).

The new provider will be setting up a 'senate' which will act as a forum for the user and citizens' voice as part of building the partnership model. The local authorities have agreed to stand down any parallel forums to ensure there is no duplication, seeing their own role as reviewing, monitoring and assuring this new structure and challenging, if and when required, to ensure its feedback is acted upon.

“Hold the line - make a commitment and stick to it. You can't talk enough and I will take that into the rest of my career”

John Denley, Public Health Consultant, Birmingham City Council

Challenges

The local authorities were aware of the close relationship between HIV and abortion services, for which they did not hold commissioning responsibility, and sexual health services. They were open to the possibility of integrating re-commissioning processes. However, aligning timetables for re-commissioning proved problematic and, therefore, co-ordination was at a strategic level through the Commissioning Group. The commissioners considered that, in this situation, this was appropriate. The size of the HIV cohort meant that a separate HIV service would be viable, unlike some areas of the country where co-location of HIV and GUM services is a requirement for service sustainability. Referral requirements and interdependencies with other services, including HIV and abortion, were clearly defined in the service specifications to

mitigate the risk of fragmented patient pathways. Coordination with other commissioners is being maintained in the mobilisation phase.

Following early public consultation on the sexual health strategy, HIV support services were 'decoupled' from the sexual health commissioning and procurement process. Re-commissioning to reflect changes in the needs of people living with HIV (PLWH) over the last 20 years, with HIV becoming a long term condition, is being taken forward by BCC's third sector commissioners with advice from public health. This approach recognised that some PLWH have complex support needs requiring a distinct strand of commissioning work to develop appropriate social care packages.

For the public health commissioning team, the biggest challenge was communicating the 'narrative for change' and engaging with stakeholders to describe their ambitions and the benefits of the new model for the populations served. The team also had to communicate the extent to which the model was 'laying new tracks' particularly on issues such as sexual violence.

The new model required a partnership and systems approach focussing on outcomes which was new to the city. The commissioning team's challenge was to foster this approach as well as stimulating the market through the stakeholder events. Bringing different players in the market together required a major investment of time and effort and a proactive approach by the two local authorities.

The size of the contract and the associated procurement process was a challenge for the small commissioning team who were simultaneously learning how to operate within their new local authority environment. There was also a pressing need to keep to a tight schedule to minimise the disruption to bidders and the current services.

Achievements

The two councils enjoy the same border but also have several differences. The approach to joint tendering was agreed by both councils and the process did not reveal significant tensions. It has allowed a greater sense of trust between the two in relation to health and wellbeing. This will be built upon in the future.

Moving from 21 main contracts to one which delivered a systems approach through a lead provider was a major achievement for commissioners. With the support of internal colleagues, notably in the procurement department, a transparent and timely process was achieved.

Councillors contributed to the market days which signalled to potential providers the new landscape in which commissioners were operating as well key messages on the local authorities' approach, fostering debate. Cabinet leads for health and wellbeing, commissioning, contracting and improvement, and children and family services received cabinet reports, supported, advised and signed off key stages in the process eg the service specifications and award of contract. The Birmingham Health & Social Care Overview and Scrutiny Committee recognised the significant change the new commissioning approach to sexual health would bring for Birmingham residents. The committee therefore included sexual health in their priorities during 2014/15. This meant that the strategy, approach and process were scrutinised by the Committee, with follow-up at 6 and 12 months on progress.

A high level of stakeholder engagement was achieved through the market days – the DsPH and the commissioning team invested considerable time and effort in communication. As the BCC DPH put it “engagement, engagement, engagement”. As a BCC public health consultant said, “spend the day talking to people out there including members” while accepting “pressures will arise – hold the line and stick to it”.

The team used all their contacts to ‘get young people in the room from diverse backgrounds’ for the young persons’ panel. For Cllr John Cotton, Cabinet member for Health and Wellbeing, their contribution represented “really good work in shaping the tender and what it would be like – a challenge to tenderers and commissioners alike”.

After the interaction of the market days and the co-production of the service specifications, selecting a procurement/contracting route which confirmed the commissioners’ commitment to on-going dialogue was essential. Using the Competitive Dialogue process facilitated this and was a ‘journey between commissioners and providers’ to reframe the approach to sexual health. A genuinely innovative response was received and its feasibility tested during the dialogue. This process was well understood by and transparent to bidders.

Successfully completing a large and complex commissioning and procurement process has enhanced the reputation of public health within the local authorities, building internal relationships. The authorities took the long-term view on improving sexual health outcomes by entering into a five-year contract period with an option to extend for a further two years. Building a coherent and integrated system and the necessary culture change will now be led by an acute trust but delivered through a community of providers.

Lessons learned

When setting out on a course leading to significant change, ‘a clear narrative on the big hits’ is essential, as the BCC DPH put it. It is equally important to ‘stick with it whatever waves may come, to ride the waves and move on’. Complex change requires transparent processes and an investment in communication and dialogue which must also be maintained with both the current and future providers after the tender has been awarded. There is no substitute for face to face meetings although these must be backed up with clear written plans eg for mobilisation and communication.

The new sexual health model will be delivered by a lead provider working with a community of providers in a sexual health system. Given the restricted nature of the market, achieving this new approach required conscious market stimulation and fostering new relationships between NHS providers and the third sector whose role in sexual health is vital. The leadership role of the DsPH was key in recognising this and proactively engaging across the acute, primary care and third sectors. As the Solihull DPH commented “you can unblock things and take them forward to achieve strategic aims we had previously struggled with”.

Local authorities were new to commissioning clinical services. Some public health commissioners do not have a clinical background and it is important to ensure clinical governance issues are well addressed in developing the model and specification and during implementation. External clinical advice was invaluable to commissioners.

The role of the third sector is central in sexual health and fostering interaction between NHS and third sector providers was one objective of market stimulation. Maintaining a vibrant third sector is important to developing a community of sexual health providers. It is necessary to understand the implications of procurement for the third sector and ensure briefing is appropriate to the range of potential providers, whose experience of procurement may differ. Third sector organisations need to be aware, for example, that exclusivity agreements are not obligatory although maintaining the confidentiality of the process is a requirement for all parties.

Whatever happens in the commissioning process, people will need to work together to deliver the five-year commissioning strategy. Informal meetings on the specification prior to the launch of the formal procurement process, involving independent organisations and external advice, maintaining the transparency of the process and ensuring clear, prompt and consistent communications were all central to maintaining working relationships with current and future providers.

“The Competitive Dialogue was refreshing – hard work but extremely worthwhile”

Jak Lynch,
Senior Commissioning Manager,
Birmingham City Council

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Sexual health commissioning in Gloucestershire

A local authority and Clinical Commissioning Group partnership

“It’s important that people across Gloucestershire can easily access sexual health support and information. The benefit of working with our partners is that all services are under one roof so that we can ensure that everyone gets the support they need when they need it”

Cllr Andrew Gravells Cabinet member for public health, Gloucestershire County Council.

“The collaborative commissioning agreement with the CCG and NHS England means we can focus on integrated service delivery and streamline performance monitoring – we don’t make multiple requests for the same information”

Sarah Scott, Interim Director of Public Health, Gloucestershire County Council.

“It can be difficult for patients facing sexual health issues to know where to turn for help. We are committed to working with our partners, including Gloucestershire County Council and NHS England, to help patients access the services and support they need, and to making this as straightforward as possible”

Dr Helen Miller, Clinical Chair, NHS Gloucestershire Clinical Commissioning Group.

Key messages

- Collaborative commissioning between the local authority, the clinical commissioning group and NHS England promotes system stability, supports seamless patient pathways and addresses the risk of service fragmentation.
- Locating public health in local government has facilitated opportunities to address the sexual health needs of vulnerable communities in collaboration with other commissioners, such as education, and services for children and young people, including those in care, and people with learning disabilities.
- Local authority commissioning processes support a focus on improving outcomes, value for money and innovation to meet community needs.

Outline

At the time of transition, Gloucestershire County Council agreed with Gloucestershire Clinical Commissioning Group (CCG) to extend the already established Joint Commissioning Partnership (for adult, children, mental health and learning disabilities services) to include sexual health commissioning. In addition to this, a Collaborative Commissioning Agreement was developed to ensure joined up commissioning arrangements between these two partners and NHS England in relation to commissioning services from Gloucestershire Care Services NHS Trust. This collective decision by the commissioning organisations promoted stability for the provider at a time of significant change in health and social care, and it streamlined commissioning processes. The Collaborative Commissioning Agreement is the framework for commissioning sexual health services in Gloucestershire. Section 76 arrangements support the financial transfers from the local authority to the CCG for sexual health services which form part of the CCG's overall contract with the local community trust. The public health team is located within the council's commissioning directorate and works with local authority commissioning colleagues and CCG counterparts to manage these partnership arrangements.

The Public Health Outcomes Manager is the council's lead officer for sexual health and also undertakes the strategic commissioning of abortion services on behalf of the CCG. Sexual health delivery is through a hub and spoke model with the hub located in Gloucester. Level three specialist sexual health, contraception and abortion services, HIV treatment and care and the Sexual Assault Referral Centre are all located at the Gloucester hub and delivered by a single provider facilitating an integrated service. The provider also undertakes training, health promotion and health advice. The spoke facilities offer level two community-based sexual health services including a designated service for young people. Level one and level two services are provided by GPs and community pharmacies.

The public health team has worked to develop its internal and external relationships to address the challenges of preserving seamless pathways and improving sexual health in a new commissioning landscape in which three organisations share responsibility for sexual health, reproductive health and HIV.

Context

Gloucestershire has a population of 605,000 people living in a mainly rural county with two urban centres, Gloucester and Cheltenham. Almost 80 per cent of the county comprises areas classified as a village, hamlet or isolated dwelling in which 20 per cent of the county's population resides compared to 40 per cent living in Gloucester and Cheltenham and 40 per cent in towns or the rural-urban fringes. The age profile of the population is 22.9 per cent aged 0-19, 58.5 per cent aged 20-64 and 18.6 per cent aged 65 and over. In the 2011 census, 4.6 per cent of the county's population were of Black and Minority Ethnic (BME) origin, considerably lower than the England average of 14.6 per cent. Gloucester has the highest proportion of BME residents at 10.9 per cent of the total population. The mix of urban and rural centres poses particular challenges in ensuring equitable access to sexual health services.

Sexual and Reproductive Health Profile data for 2013 demonstrate Gloucestershire is succeeding better than the England average on most indicators. Challenges remain and there are pockets of deprivation and poor sexual health in both urban and rural areas. Chlamydia detection rates per 100,000 population aged 15-24 years are below the England 2013 average of 2,016 in Gloucestershire at 1,728 and do not meet the target of 2,300. The percentage of abortion under 10 weeks is 75.5 per cent compared to an England average of 79.4 per cent. HIV prevalence is low at 0.89 per 1,000 aged 15-59. HIV late diagnosis is 44.3 per cent, slightly below the England average of 45 per cent and the under 18 conception rate has fallen by over 50 per cent since 1998.

Sexual health commissioning in Gloucestershire

Objectives

Gloucestershire County Council's objectives for sexual health commissioning are to:

- maintain an integrated model of care for sexual health through its collaborative commissioning arrangements with the local CCG.
- undertake sexual health needs assessment in collaboration with the CCG, NHS England and the sexual health strategic partnership group.
- ensure public health contracts for sexual health services, including those in primary care and HIV prevention, provide the best outcomes and value for money for the residents of Gloucestershire.

“Being in a local authority has opened doors for us we didn't know existed. Working with commissioners supporting the needs of young people and adults we are able to better understand and react to the needs of those vulnerable to poor sexual health”

Karen Pitney, Public Health Outcomes Manager, Gloucestershire County Council.

Approach

A joint commissioning board between the CCG and local authority oversees all jointly commissioned adult, children, mental health and learning disabilities services covered by Section 75, Section 76 and Section 256 agreements. A collaborative commissioning agreement and collaborative commissioning

group composed of a public health consultant and senior Council, CCG and NHS England managers oversee the operation of the joint arrangements.

Service specifications for sexual health services (GUM, contraception, psychosexual medicine and sexual health promotion) drawn up by the local authority public health team are part of the CCG contract with the NHS community trust which is the sexual health provider. The Public Health Outcomes Manager, as lead for sexual health, works with her CCG commissioning and finance counterparts on day to day oversight of contracts. The approach to joint commissioning has been developing and new service specifications were agreed in 2014/15 to clarify outcomes and monitoring requirements for commissioners and the provider.

A Sexual Health Strategic Partnership Group (SHSPG) on which the local authority, CCG, Healthwatch, the community trust and other providers are represented builds commissioner and provider relationships. Membership includes the service manager and clinical leads of the sexual health service provider and the local authority's youth services. There is a matching implementation group which, as a sub-group of the SHSPG, takes forward agreed priorities at the operational level. An action plan was approved by the SHSPG to prioritise and take forward recommendations arising from the sexual health needs assessment. A quarterly update on the action plan is a standing item at the operational group. Regular updates are also made to the SHSPG which monitors progress on its agreed sexual health strategy for 2012-2017. The public health team has worked hard to develop a shared understanding of the priorities with providers in the context of the new commissioning landscape. The imperatives arising from public health located within local authorities include a focus on outcomes, value for money and innovation to meet community needs.

In addition to developing the approach to joint commissioning, the public health team has also led a sexual health needs assessment.

This afforded the opportunity to utilise council mechanisms for community engagement such as the on-line tool, 'U engage', which attracted 150 responses to individual and stakeholder questionnaires on sexual health services in Gloucestershire. The team also organised an engagement event attended by over 80 people using an open space methodology and focus groups for under-represented communities.

The local authority recently consolidated a number of HIV prevention and social care services under a single contract provided by the Eddystone Trust. This was the Public Health Outcomes Manager's first experience of commissioning in a local authority which was described as 'very hands-on'. The public health team benefitted from 'great support' from other local authority teams on the legal aspects of procurement but also on the process of working with elected members. Having a single provider for prevention and social care has streamlined relationships with HIV treatment and care services and facilitated consistent care pre- and post-diagnosis for people living with HIV and their carers.

A round of public health contracting with 85 GP practices and 106 pharmacies has also been completed, working closely with the Local Medical and Pharmaceutical Committees. In a largely rural county, the input of primary care to sexual healthcare is important and the contracting exercise was a 'learning curve' for all parties. The GP contract includes a training allowance triggered by attendance at training and cascading it in the practice. This is a new element of the contract aimed at ensuring GPs retain an interest in sexual health and maintain their skills to provide contraceptive devices and access for women to a full range of contraception. Training for pharmacists is included in the 'Healthy Living Pharmacy' scheme. Work on this is led by the Public Health Outcomes Manager, who, in addition to her responsibilities for sexual health, also leads on NHS Health Checks.

"The ring fence may still be on but we still have to challenge ourselves to demonstrate value for money, getting the right service in the right place in the right way"

Sarah Scott, Interim Director of Public Health, Gloucestershire County Council.

Challenges

The public health team faced the simultaneous challenge of embedding itself within local government and developing new ways of working with colleagues in the CCG and NHS England to deliver jointly on sexual health objectives within a collaborative commissioning framework. A shared commitment to maintaining seamless pathways of care and avoiding fragmentation of services has been underpinned by developing new service specifications and monitoring arrangements.

The public health team sits at the fulcrum of three commissioning processes and has worked hard to ensure a full understanding of CCG and NHS England commissioning cycles within the local authority. As the Public Health Outcomes Manager put it, "we have continued to work collaboratively despite the phenomenal change".

Commissioning in local government has a keen focus on demonstrating population and community benefit as well as high expectations of community engagement in priority setting, political scrutiny and involvement in decision making. The public health team has not only had to ensure its own understanding and compliance with new imperatives but has also had to build the understanding of providers who may be unfamiliar with local government culture and processes.

Achievements

The public health team and its CCG counterparts have developed a joint approach to commissioning sexual health services supported by the collaborative commissioning and section 76 agreements which has ensured stability across the system. Placing strategic commissioning for sexual health, including supporting the CCG with the commissioning of pregnancy advisory services, within the local authority public health department, while the CCG acts as lead contract manager, has addressed the risk of fragmentation in the new commissioning landscape. This approach streamlines commissioner-provider relationships where there is a single provider so that, for example, activity data is provided once only and service users experience a single pathway.

Local authority public health contracts have been developed and used to commission a community organisation and primary care providers for level one and two services within the hub and spoke model. These are particularly important for achieving improved outcomes in HIV prevention and meeting women's contraceptive needs in a mixed rural and urban county.

The Public Health Outcomes Manager has built relationships with fellow commissioners in the local authority to address the sexual health needs of people with learning difficulties and children in care. These have resulted in outreach services at a facility for people with learning difficulties, FPA training for carers of children in care and nurse outreach in the fostering and adoption services.

The public health department is represented on the Sexual Assault Referral Centre board by the Public Health Outcomes Manager who also provides input into the domestic abuse and sexual violence agenda in the local authority. This crossover provides an important link between prevention and clinical service delivery.

Lessons learned

The public health department has a key role in supporting commissioners in developing outcome measures for sexual health services which emphasise prevention, information and education as well as diagnosis and treatment.

Locating the public health department in the commissioning directorate facilitates linkages with commissioners of services for adults, children and people with learning difficulties. These can be used to develop initiatives which meet the needs of vulnerable communities at risk of sexual ill health.

Good financial and activity data is required to support collaborative commissioning arrangements through a Section 76 agreement. Although time consuming, the process of attributing funding to specific services and contracts is useful and, when linked to activity and outcomes data, will provide a basis for assessing value for money.

“We have to constantly take account of the patients’ voice, see what might be a priority for investment, how a new pathway might work and how to demonstrate population and community benefit”

Karen Pitney, Public Health Outcomes Manager, Gloucestershire County Council.

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Collaboration by London local authorities to address sexual health commissioning challenges

“Sexual health is one third of the public health budget, we need to get it as right as we can. The community of local authorities has come together in a ‘coalition of the willing’ to shape the future of these services”

Mike Cooke, Chief Executive, London Borough of Camden and Chair, London Sexual Health Board.

“We now have a very clear in depth picture across London of what the needs are and how people move across the capital in an open access service. We have to get to a clinically and financially sustainable position to ensure the services of the future”

Jonathan O’Sullivan, Deputy Director of Public Health, Camden and Islington.

Key messages

- Bringing together Directors of Public Health (DsPH) and sexual health commissioners through the Association of Directors of Public Health (ADPH) has fostered collaborative working practices and led to pan London projects.
- London local authorities (LAs) can work together at scale and at pace to collaborate on public health, recognising

the importance of preserving open access and preventing STIs and HIV. They have joined together in a variety of groupings using a range of mechanisms: coordination, sharing of information and experience, needs assessment for HIV prevention, a London-wide HIV prevention programme, collaborative genitourinary medicine (GUM) commissioning and a sexual health services transformation project.

- Developing a ‘case for change’ and reform of sexual health services in London requires senior sponsorship, strong programme management and all the talent and expertise of participating DsPH and sexual health commissioners.

Outline

There is significant sexual ill health in London. The need for sexual health services is higher than the England average and continues to rise. London councils recognise sexual health and HIV as key public health issues. All 33 London councils participate in the Association of Directors of Public Health London network for directors of public health, its work programme, allied commissioners’ network and the London HIV Prevention Programme (LHPP) described the case study on page 11. The LHPP is a flagship initiative. It brought DsPH together, initially brokered by London Councils, to develop a London-wide response with the support of council leaders.

The lead London chief executive describes collaborative work on sexual health as “a coalition of the willing”. Collaborative initiatives arose from an early recognition that LAs needed to work sensibly and proactively on strategic sexual health issues in response

to rising demand and needs, and the complexity of what had become a fragmented set of services.

London LAs recognise that open access to services, population mobility and high levels of deprivation and sexual ill health, along with significant local variation in needs, mean a mix of London-wide and local responses is required. In addition to HIV prevention, London-wide work is being undertaken under the ADPH (London) umbrella on the proposed integrated sexual health tariff and the development of Patient Group Directions (PGDs).

There is high and rising demand for sexual health services which are already allocated a significant percentage of public health budgets. It is projected that, without action, almost 100 per cent (or more) of those budgets will be spent on sexual health in under five years. This has underpinned the need for action and fostered the collaborative responses between London councils described in this case study.

Collaborative approaches have been adopted by a majority of London LAs to GUM commissioning, a C-card scheme and the sexual health services transformation project. 22 London councils have now made 'a case for change' in the commissioning of GUM services and system-wide reform and transformation of sexual health services.

Context

London has a population of 8.6 million of which 3.8 million (44 per cent) are of black and ethnic minority (BME) origin. London's population is young and highly mobile.

There are significant inequalities in sexual health with gay, bisexual and other men who have sex with men, some BME communities and younger adults, particularly socially and economically disadvantaged young women, experiencing high levels of sexual ill health. London has higher rates of sexually transmitted infections, including HIV, than any other part of the country. The HIV diagnosed

prevalence rate per 1,000 aged 15-59 is 5.69 compared to an England average of 2.14. Many London LAs have made progress in addressing late diagnosis of HIV which is now 40.5 per cent compared to an England average of 45 per cent. Chlamydia detection rates at 2,179 per 100,000 aged 15-24 exceed the England average of 2,016. London has higher new diagnoses of STIs (excluding chlamydia in those aged under 25) at 1,492 per 100,000 compared to 832 for England. London also has significantly higher diagnosis rates of syphilis and gonorrhoea per 100,000 population: 19.8 for syphilis and 155.4 for gonorrhoea compared to 5.9 and 52.9 for England.

The percentage of repeat abortion for under 25's in London is 32.6 per cent of all abortions, exceeding the England average of 26.9 per cent. London also has lower levels of long-acting reversible contraception (LARC) prescribing by GPs at 25.1 per 1,000 compared to an England average of 52.7. London's under 18 conception rate of 21.8 per 1,000 is lower than the England average of 24.3.

There are more than 30 GUM clinics in London. Residents frequently access clinics outside their LA of residence. Use of sexual health services reflects patterns of commuting, work, study, social and leisure activities, open access to services and the location of clinics, for example, near LA boundaries or central London places of work.

Collaboration on sexual health in London

Objectives

The London Sexual Health Services Transformation Project aims to:

- deliver a new collaborative commissioning model across the participating councils for sexual health services in London, in particular open access GUM services
- improve the patient experience and sexual health outcomes
- provide successful cost effective delivery of excellent services across the capital.

Approach

Much of the collaborative work described in this case study is 'work in progress'. Important milestones are described although these focus more on process than outcomes due to the stage reached in many of the collaborations described.

There are two ADPH leads for sexual health and an ADPH HIV prevention lead for London. Under the umbrella of the ADPH, DsPH initially focussed on the London HIV Prevention Programme (LHPP). The governance and activities of the LHPP are described in the case study on page 11. All London councils are participating in networking between DsPH and between sexual health commissioners with the objectives of sharing information and identifying work best done across the capital. As one of the ADPH London leads confirms, since transition "to a large extent DsPH have met together to make sure we go forward on the main issues".

The commissioners' network is supported by two part-time coordinators. One coordinator focuses on strategy and stakeholder engagement, the other advises on the

technical processes of commissioning as well as being a local sexual and reproductive health commissioner. London sexual health commissioners also meet on a quarterly basis supported by the co-ordinators.

Current ADPH London work streams include the review of the proposed integrated sexual health tariff, with the objective of updating the activity and case mix data on which a new integrated tariff would be based, and refreshing pathways based on updated clinical guidelines. There is also a project to develop PGDs to ensure consistent standards of sexual healthcare across the capital. PGDs allow appropriately qualified specialist nurses to provide a defined range of medications to patients subject to specified inclusion and exclusion criteria. In sexual health, PGDs cover hormonal contraceptives and treatment of common sexually transmitted infections.

Nine local authorities in NW London commissioned GUM services collaboratively in 2013/14 in recognition of the movement of patients across organisational boundaries. The arrangement grew to 12 authorities in 2014/15, 20 for 2015/16 and it has now reached 27. A steering group for this work is chaired by the deputy DPH, Camden and Islington. A common service specification was developed and performance indicators agreed, including a mix of clinical standards and service metrics. Standard terms and conditions are based on the non-NHS public health contract. There is a lead commissioner for each provider trust and a single contract to which the other LAs are party. The lead commissioner agrees prices and contractual activity parameters on behalf of the collaborative but each LA remains responsible for payment for actual activity. There is an underlying agreement between the LAs, the terms of which were developed by the legal department of one of the participating councils. Its objectives are to support the operation of open access services recognising the substantial movement of patients between LAs, realise economies of scale and deliver benefits to LAs and providers from collaborative commissioning, which greatly reduces

the number of contracts and eliminates duplication of reporting and performance monitoring.

The sexual health services transformation project is a phased programme led by the Chief Executive of the London Borough of Camden on behalf of the 22 participating councils. The work is supported by a programme manager and lead DPH. The first phase developed the case for and options for change. It involved needs assessment, modelling cross boundary flows, developing potential options for collaborative commissioning and reviewing service models. It was based on extensive engagement with public health and sexual health commissioners on current service models, gaps and pressures and how a future model might address these. The second phase will develop the collaborative commissioning and service model. This will include engagement with stakeholders including clinicians, providers and service users. The councils recently issued a Prior Information Notice (PIN) “seeking to engage with and obtain the views of providers of sexual health services”. The PIN is a pre-procurement exercise to help develop thinking on the way in which sexual health services might be provided in London in the future.

“To a large extent DsPH have met together over the last two years and we need to make sure we go forward together. The transformation programme will influence how public health is perceived in a local authority environment, how we control things and lead change”

**Dr Penny Bevan,
Director of Public Health,
London Borough of Hackney,
and Sexual Health Lead, ADPH.**

Challenges

The move of sexual health commissioning to local authorities, with a significant proportion of the public health budget allocated to clinical services, presented two inter-related early challenges. The first was to build understanding amongst local authority staff about the public health significance of sexual health services and particularly the value of early intervention and prevention.

The second early challenge was to increase confidence amongst providers and clinicians about local authorities’ good intentions and the opportunities for a ‘win-win’ approach. Providers also had to be informed about the rules under which local government operates, particularly in procurement where LAs are used to letting contracts for three to five years, and its experience of supporting innovation.

A further challenge, but also an opportunity, is ensuring LA links are established to NHS England and CCGs, as commissioners of HIV treatment and care and abortion services respectively. This is important because HIV and GUM sexual health services are usually co-located and delivered by joint teams, while abortion services are an integral part of sexual and reproductive healthcare pathways for women.

Working across 33 London councils is a challenge and to date funding has been allocated on a project by project basis for each ADPH-supported work stream ie commissioner coordination, the integrated tariff and PGD development. The principle of a commissioning network has been broadly accepted, although the work is not branded or structured as occurs in LHPP governance where one DPH or their nominee represents each of five London sectors. These cover North West, North East, North Central, South East and South West London respectively.

Agreeing a single contract on behalf of a range of other councils requires considerable investment of time and effort by legal and procurement departments whose support

is instrumental in overcoming this challenge and making contracts work. Different councils also have differing priorities and getting to a fair offer for GUM commissioning that all concerned councils can endorse requires a willingness to co-operate and come to a shared view.

Public health has been integrated into local government in a variety of ways and, in some London LAs, sexual health commissioning is not undertaken from within public health. Councillors' decision-making and governance is paramount and public health and commissioners have to negotiate local processes to ensure 'sign-up' to collective approaches, for example tendering waivers. This can be time-consuming and requires completion by all participating councils for collective processes to be enacted.

“Commissioners’ network meetings are very well attended, we had 29 councils in the room last time. We are continuing to take forward collaboration to improve quality and reduce costs”

**Peter Taylor,
London Sexual Health Strategic
Commissioning Coordinator.**

Achievements

Bringing together DsPH and sexual health commissioners through ADPH London has fostered collaborative working and led to specific projects of benefit to all councils. The appointment of the strategic commissioning coordinators has helped support strong commissioning at local level as well as identifying common strategic issues and building solutions on a project by project basis.

London councils have succeeded in developing an approach to collaborative GUM commissioning and a common offer with

good engagement from a majority of councils within a relatively short space of time. A service specification, key performance indicators (KPIs), common activity data requirements and a legal framework have already been agreed. These promise greater control over expenditure as well as a saving of time and effort for providers who will avoid multiple negotiations and duplication of data submission, monitoring and performance management requirements.

To inform longer-term commissioning plans, a very clear in-depth picture across the capital of sexual health needs and how people move through an open access service has been developed by the sexual health services transformation project. This drew on quantitative analysis of trends with great support from the Public Health England epidemiology team. This aspect of the project is complemented by a comprehensive review of evidence on effective service models and potential future options.

Lessons learned

London LAs can work together at scale and at pace to collaborate on public health, recognising the importance of preserving open access and preventing STIs and HIV. Working on this larger scale is also a good way to call on talents and expertise across LAs, thus maximising the use of resources. Such collaboration requires responsible councils to deliver on their undertakings on behalf of the collective.

A large and complex programme such as the sexual health services transformation project requires strong, dedicated project and programme management and leadership to move forward and manage risks. Senior sponsorship from a health sub-group of London council chief executives and DsPH has proved vital to keep the participating councils fully involved and committed. The lead chief executive's leadership role helps navigate the complexity of inter-organisational relationships and keeps other chief executives updated on progress. A wider stakeholder

engagement approach aiming to build confidence, as adopted in phase two of the project including the PIN issued to providers, signifies a commitment to proactive dialogue and to sustainable innovation. Briefing and engaging council leaders and cabinet members will also be key, as the experience of the LHPP demonstrated, given the significant proportion of the public health grant allocated to sexual health services.

“It is quite an undertaking to get 27 councils together and we need to respect the sovereignty of local decision-making in each council”

**Jonathan O’Sullivan,
Deputy Director of Public Health,
Camden and Islington.**

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