

# Sexual health commissioning in local government

Collaborating for better  
sexual and reproductive  
health and wellbeing

Written by  
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# Foreword

The sexual and reproductive health of local populations depends on councils adopting a whole-system approach to service commissioning, in partnership with NHS colleagues.

The challenges are great. Sexually transmitted infections (STIs) and unplanned pregnancy are amongst the most important contributors to poor health, particularly in the most deprived neighbourhoods. Public Health England reports a 5 per cent increase from 2017 to 2018 in STI diagnoses in England, reaching a total of 447,694. For gonorrhoea, the increase was a startling 26 per cent. New diagnoses of HIV have recently declined thanks to treatment coverage and new prevention drugs, but late diagnosis, the leading cause of premature death and disease among people living with HIV, remains too high.

A consistent fall in teenage pregnancies over recent years, down to the lowest rate since 1969, is a testament to the systematic application of successful strategies, including education, support and access to comprehensive sexual health services. However, the substantial variation in rates between local authorities, ranging from 6.1 to 43.8 conceptions per 1,000 15- to 17-year-olds, leaves no room for complacency.

Grasping our responsibility for sexual health commissioning since the transfer of public health to local government in 2013, councils have been working hard, in collaboration with NHS partners, to maintain and improve access for our residents to sexual and reproductive health services and to ensure seamless pathways of care.

Major service transformation has been achieved in many areas in the face of significant cuts to both local authority central revenue funding and public health grants, as well as rising demand for sexual health services (3.5 million attendances at sexual health clinics in England in 2018, compared with 2.9 million attendances in 2013).

In this context, the capacity of councils to further innovate and create efficiencies is now limited without an increase in spending power. We therefore look to the forthcoming Spending Review to provide a level of public health funding that will enable us to maintain high-quality sexual health services and invest in prevention. This will not only improve people's sexual health and wellbeing, but also provide savings down the line for NHS and social care services.

We welcome the Government's recent announcement that councils will continue to commission sexual health services. Local government is uniquely placed to prioritise prevention, make the links required to address the social determinants of health and tackle inequalities. We agree with the Government on the need for more joint working between local authorities and the NHS to co-commission services for sexual health. Integrated care pathways are key, as poorly connected services mean a risk of people falling out of the system without receiving the care they need.

These timely case studies provide examples from around the country of councils collaborating, both among themselves and with CCGs and NHS England, to commission integrated services and improve the sexual health and wellbeing of their local populations. They showcase joint commissioning in urban and rural areas, by councils with widely varying population profiles and facing differing sexual health challenges. They are written to a level of detail intended to enable others to imitate their approach.

Too often, good practice remains hidden. Through this publication we aim to share it and enable others to benefit from the learning it can provide.



**Councillor Ian Hudspeth**

Chairman, LGA Community Wellbeing Board

# Introduction

## Sexual health commissioning case studies

Local government is working in a variety of ways with partners in the NHS to take a collaborative approach to the commissioning of sexual health, reproductive health and HIV, following the re-allocation of commissioning responsibilities arising from the Health and Social Care Act 2012. These six case studies present examples from around the country, demonstrating how collaborative and whole-system approaches have been developed to overcome a number of specific challenges and take advantage of opportunities offered through the commissioning of sexual and reproductive health by local government.

The publication of the case studies could not be more timely, coming in the wake of the House of Commons Health and Social Care (HSC) Committee's report on sexual health<sup>1</sup>, and the Government's subsequent announcement of the recommendations<sup>2</sup> from its review of commissioning arrangements for sexual health services.

This publication will support local government councillors and officers with public health and sexual health responsibilities to collaborate with colleagues across the system and to maximise the effectiveness

of their commissioning practice. It will also be of interest to commissioners in clinical commissioning groups (CCGs) and NHS England. The innovative solutions it describes should be noted by the Department of Health and Social Care as it consults through its prevention Green Paper<sup>3</sup> on priorities for a future sexual and reproductive health strategy.

## Developing the case studies

In 2015, the Local Government Association (LGA), with MEDFASH, published a series of case studies<sup>4</sup> giving examples of sexual health commissioning since local government took over this responsibility in April 2013. Four years on, the LGA has commissioned these six new case studies to showcase more recent examples of sexual and reproductive health commissioning by local government, with NHS partners.

To identify potential case studies, the LGA wrote to directors of public health and to Public Health England calling for suggestions. Eighteen responses were received, of which six meeting the stated criteria were selected for inclusion in the publication – representing different types of local authority from around the country, with varied geographic, demographic and political profiles. Three interviews were conducted by the project consultant to develop each case study (usually with the lead sexual health commissioner(s), a director of public

1 House of Commons Health and Social Care Committee. 'Sexual health: fourteenth report of session 2017-19'. [www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/sexual-health-inquiry-17-19/](http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/sexual-health-inquiry-17-19/)

2 'Government review confirms local authorities will continue to commission public health services.' Government news story, 7 June 2019. [www.gov.uk/government/news/government-review-confirms-local-authorities-will-continue-to-commission-public-health-services?utm\\_source=cdf7c676-b169-492e-8f66-48878c42ea0a&utm\\_medium=email&utm\\_campaign=govuk-notifications&utm\\_content=immediate](http://www.gov.uk/government/news/government-review-confirms-local-authorities-will-continue-to-commission-public-health-services?utm_source=cdf7c676-b169-492e-8f66-48878c42ea0a&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate)

3 Advancing our health: prevention in the 2020s – consultation document. Cabinet Office and Department of Health and Social Care, 22 July 2019. [www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document](http://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document)

4 'Sexual health commissioning in local government: building strong relationships, meeting local needs.' LGA and MEDFASH, 2015. [www.local.gov.uk/sexual-health-commissioning-local-government](http://www.local.gov.uk/sexual-health-commissioning-local-government)

health and a partner from the NHS or another council), and the drafts were corrected and approved by the interviewees. A panel of expert advisers provided guidance and comment at different stages of the project.

## Policy context

The Health and Social Care Act 2012 divided responsibility for commissioning sexual health, reproductive health and HIV services between local government, CCGs and NHS England (see Appendix). Local government took on a significant role as part of its broader new responsibilities for public health, with the requirement to commission certain mandated, as well as non-mandated, sexual health services. Recognising the potential for fragmentation of service provision arising from the new arrangements, Public Health England published 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV'<sup>5</sup> in 2014.

Since then, a number of collaborative commissioning arrangements have been developed, but there remains significant variation in local practice. In 2017, a survey by Public Health England with the Association of Directors of Public Health (ADPH) found some excellent examples of service improvement, recasting of service specifications to meet assessed needs and collaborative approaches, but little evidence of systematic collaborative working across all three sectors (councils, CCGs and NHS England). It also found evidence of issues which had the potential to impede effective commissioning, notably: fragmentation, difficulties with access to services (especially for those at highest risk), contracting problems (including cross-charging for out-of-area attendances), workforce issues, increasing demand for services, and financial pressures due to budget reductions – particularly in local government.

5 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV.' Public Health England, 2014. [www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services](http://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services)

A number of these concerns, especially the impact of fragmentation, have also been documented in reports from two all-party parliamentary group inquiries<sup>6,7</sup>, the King's Fund<sup>8</sup>, and the main professional bodies representing GPs<sup>9</sup> and sexual health clinicians<sup>10</sup>.

In response to these continuing concerns, the House of Commons HSC Committee launched an inquiry into sexual health. Its report, published in June 2019, points out that, despite declining rates of sexually transmitted infections (STIs) and teenage pregnancies overall, there are seriously concerning underlying trends and inequalities as certain groups bear a disproportionate burden of poor sexual health. (Since the report's publication, the latest statistics have shown STI diagnoses starting to rise again) it concludes that fragmentation remains a significant obstacle to effective commissioning, along with severe cuts to spending and rising demand for services. Highlighting the 14 per cent real-terms reduction in local authority spending on sexual health between 2013/14 and 2017/18 due to successive cuts in the ring-fenced public health grant, it observes that reduced spending on sexual health leads to higher costs for the wider health system, as well as potentially serious long-term health consequences for individuals.

6 'The HIV puzzle: piecing together HIV care since the Health and Social Care Act.' All-Party Parliamentary Group on HIV and AIDS, 2016. <https://static1.squarespace.com/static/5b7d333855b02cc3853805ce/t/5bb22075e4966b598c32e434/1538400375686/hiv-puzzle-report-2016.pdf>

7 'Breaking down the barriers: the need for accountability and integration in sexual health, reproductive health and HIV services in England.' All-Party Parliamentary Group on Sexual and Reproductive Health, 2015. [www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf](http://www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf)

8 'The future of HIV services in England: shaping the response to changing needs.' The King's Fund, 2017. [www.kingsfund.org.uk/publications/future-hiv-services-england](http://www.kingsfund.org.uk/publications/future-hiv-services-england)

9 'Sexual and reproductive health: time to act.' Royal College of General Practitioners, 2017. [www.rcgp.org.uk/-/media/Files/Policy/Media/8895-RCGP-Sexual-Health-online.ashx?la=en](http://www.rcgp.org.uk/-/media/Files/Policy/Media/8895-RCGP-Sexual-Health-online.ashx?la=en)

10 'Government funding cuts leave sexual health and HIV care at breaking point.' British Association for Sexual Health and HIV, 2018. [www.bashh.org/news/news/government-funding-cuts-leave-sexual-health-and-hiv-care-at-breaking-point](http://www.bashh.org/news/news/government-funding-cuts-leave-sexual-health-and-hiv-care-at-breaking-point)

The report calls for sufficient funding to deliver high-quality services and recommends the development of a new national sexual health strategy, identifying a number of priority areas for this to address.

Against the backdrop of the House of Commons HSC Committee's ongoing inquiry, the NHS Long Term Plan<sup>11</sup>, published in January 2019, stated the Government's intention to consider what the best future commissioning arrangements for sexual health services might be, including a potentially stronger role for the NHS. Referring to this, the committee's report rejected the idea of moving sexual health commissioning back into the NHS, concluding that "strengthened collaboration is key". Echoing this, the Secretary of State for Health and Social Care announced that public health responsibilities would remain with local government, but there should be a shift towards joint working with the NHS to co-commission services specifically for sexual health. He stated that the forthcoming prevention Green Paper would look at how action on this could be taken forward

In the interviews conducted for these case studies, directors of public health and sexual health commissioners took a similar view to the committee's. They agreed that sexual health commissioning should remain within local government, citing a number of advantages to this positioning – such as the way it facilitates the prioritisation of prevention; the closer links it enables with education, youth services, community safety, other relevant local government departments and the voluntary sector; and its potential to impact the wider determinants of health. When asked about the future, although some acknowledged that financial pressures had stimulated innovation and technical advances, the overriding concern was how to meet the challenge of starkly decreasing financial resources and rising demand for services. Some hoped that more formal joint commissioning responsibilities around sexual health might be put in place.

11 'NHS Long Term Plan', 2019. [www.longtermplan.nhs.uk](http://www.longtermplan.nhs.uk)

The HSC Committee report states that: "There is a need to...address the unacceptable variation in joint collaborative working across commissioning. The reasons for this need to be addressed, including by making sure all areas are supported to follow the best practice." It is hoped this selection of case studies will play a role in providing that support.

## Learning from the case studies

### **Collaborative commissioning**

In all the case studies, commissioners emphasise the benefits of commissioning collaboratively. In three (Teesside; Leicester, Leicestershire and Rutland; and Lambeth, Southwark and Lewisham), councils joined together across an area to commission a single integrated sexual health service, thus gaining economies of scale, a stronger voice when negotiating with providers and an understanding of population-based data across a wider geographical footprint – particularly useful where large numbers of people cross local authority boundaries to access services. Elsewhere, in Cheshire and Merseyside, nine councils use a common service specification to procure their individual sexual health services, ensuring standardisation across the whole area.

Councils in the case studies are also working closely with NHS commissioners to plug potential gaps in service provision and use resources more cost-effectively. Gloucestershire County Council, with its local CCG and NHS providers, piloted an integrated contraception offer in maternity services, aiming to reduce negative outcomes for vulnerable women and their families and to provide a system-wide return on investment. In Cheshire and Merseyside, the councils' common service specification requires sexual health services to provide cervical screening (a key priority in the HSC Committee report) under contract with NHS England. In Leicester, Leicestershire and Rutland, councils used Section 75 agreements to



commission the fitting of intra-uterine systems (IUSs) for heavy menstrual bleeding on behalf of the CCGs, making more cost-effective use of the qualifications and skills of clinicians who fit IUSs for contraceptive purposes.

In Lambeth, Southwark and Lewisham, the local authority commissioning team manages abortion service contracts on behalf of the three CCGs, facilitating an integrated response to their local population's reproductive health needs in order to reduce unwanted pregnancies and associated health inequalities. In Teesside, four councils, two CCGs and NHS England are partners in a single contract through which they commission an integrated sexual health service, enabling them to share a focus on prevention and gain efficiencies by centralising contract management and administrative functions. In Plymouth, sexual health commissioning is supported by the city's overall shared strategic vision and integrated commissioning function, whereby several council and CCG budgets are pooled.

Some of the case studies showcase collaborative relationships between commissioners and providers. Plymouth's negotiated procedure for commissioning fostered relationships of trust and shared system leadership, facilitating the culture change and flexibility necessary for service transformation. In Gloucestershire, enabling midwifery teams to play a lead role in designing new pathways within their own service generated workable solutions and staff motivation to implement them.

### **Making collaborative commissioning work**

As the case studies demonstrate, successful collaborative commissioning depends on strong relationships, a clear shared vision, equal respect for each partner's priorities and a willingness to compromise. It is important to build in sufficient time to ensure all partners' needs are addressed and their different approval processes are followed. Locating the commissioning function within one council on behalf of several councils and CCGs can provide efficiency savings and the capacity to take a strategic focus on improving outcomes

and reducing costs, although the feasibility of this model may vary depending on local authority size and geography.

Appointing a single contract manager, working equally to the requirements of all collaborative partners, can ensure that communication among and between commissioners and providers is streamlined and consistent. However, where the cultures of collaborating councils are very different, there may sometimes be advantages in retaining separate commissioning leads who take a coordinated approach between them.

Joining up commissioning does not have to be complicated, controversial or large-scale. For example, adding an extra schedule to existing Section 75 agreements, as in Leicester, Leicestershire and Rutland, is a relatively simple mechanism for delegating the commissioning of specific services, such as IUS fitting for non-contraceptive purposes, from CCGs to councils. Making cervical screening under contract with NHS England a requirement in council-commissioned sexual health service specifications is a pragmatic and fairly straightforward way of maintaining access to, and encouraging uptake of, screening.

### **Optimising commissioning outcomes**

Joint commissioning across a larger geographical footprint and with a combined budget, as in Teesside, can create a more attractive procurement option for providers, increasing the likelihood of one or more strong bids. Longer contracts with options for extension can also be beneficial for both commissioners and providers, giving more time to reap the rewards of investment in the tendering process and to allow innovations to become embedded in the service.

In all the case studies, public health team members played a leading role in commissioning. Basing commissioning on assessment of local needs (including factors driving inequalities in sexual and reproductive health) and on analysis of current patterns of service use can bring better outcomes than using a more purely contractual commissioning model.

Focusing on local population needs can also facilitate agreement between council and NHS commissioners on shared goals. It is not necessary for public health staff to have technical expertise in procurement if this can be accessed elsewhere within the same council.

Collaboratively commissioning a single integrated sexual health service provides an opportunity to develop a highly trained and flexible sexual health workforce, able to provide a 'one-stop-shop' service and to move between sites as needed. Commissioners can ensure that training arrangements are built into contracts with providers, including the role of specialist sexual health services in training clinicians in primary care and community services. More specifically, where the provision of two services requires the same training and qualifications for clinicians, it makes the most cost-effective use of resources to commission them both from the same workforce, as with the commissioning of IUS fitting for contraceptive and non-contraceptive purposes in Leicester, Leicestershire and Rutland.

### **Driving transformation through system leadership**

Public health leaders in different commissioning organisations across the system play a key role in identifying ways to join up commissioning and service provision for the benefit of local populations. The case studies provide examples where directors of public health and their teams worked with colleagues in NHS England (such as cervical screening leads) or CCGs (such as abortion or maternity service leads), as well as with each other. A notable example is the Cheshire and Merseyside Public Health Collaborative (CHAMPS), which works across nine local authority areas, has a lead director of public health for sexual health, and provided a 'home' for a jointly funded programme lead post which was agreed to be necessary in order to drive transformational change.

Strong leadership from public health directors, supported by a commissioning team with a clear mandate and resources to take this forward, can enable effective collaborative commissioning. This was evident in a number of the case studies, where the director's role often involved approving key decisions, providing support, troubleshooting when necessary and ensuring senior colleagues and councillors were briefed and engaged. Public health directors interviewed for the case studies described their leadership roles across the system, including in one area where this was facilitated by an integrated care system (ICS). Although often focused on other priorities, for example health and social care integration, joint governance structures such as ICSs or sustainability and transformation partnerships (STPs) can potentially enable sexual and reproductive health initiatives to be commissioned and assessed for their impact across the wider system, as in the case study from Gloucestershire.

The case studies also provide examples of engagement from political leaders, including portfolio holders, who can play a key role as champions for sexual and reproductive health across council departments, with fellow councillors and in decision-making forums. Their support can be particularly valuable when commissioners are dealing with an issue that may be politically sensitive, such as considering the setting up of 'buffer zones' around abortion clinics, as in Lambeth, Southwark and Lewisham.

# Case studies

# A single contract for sexual health services across Teesside

Four local authorities, two CCGs and NHS England collaboratively commission a prime provider

“What we didn’t want to do, and all parties were agreed, was to have a split just because of the change in commissioning responsibilities across the CCGs, NHS England and local authorities.”

**Jayne Herring**

Commissioning and Delivery Manager – Planned Care, NHS South Tees Clinical Commissioning Group

“With joint commissioning we are able to deliver a comprehensive sexual health service for the local population. This enables improved outcomes through holistic and joined-up delivery approaches, as well as providing a better experience for the service user.”

**Edward Kunonga**

Director of Public Health, Public Health South Tees, Middlesbrough Council and Redcar & Cleveland Council

## Keys to success

- Strong leadership from public health directors, supported by a team with a clear mandate and resources to take this forward, enables effective collaborative commissioning.
- Joint commissioning across several councils and the NHS makes the service more flexible and resilient in responding to current and emerging population needs and is more attractive to providers.
- Where several commissioning organisations are involved, it is beneficial to streamline governance arrangements by appointing one lead local authority and one contract manager.

## Outline

Sexual Health Teesside is commissioned by the four Tees councils (Stockton-on-Tees/ Middlesbrough/Redcar & Cleveland/ Hartlepool), two CCGs (Hartlepool and Stockton-on-Tees/South Tees) and NHS England. It has provided a fully integrated community-based sexual health service since 2011, which includes formerly hospital-based genitourinary medicine (GUM) and community-based contraception and sexual health services, along with the chlamydia screening programme. Following an extensive review and consultation exercise, the service was re-commissioned in 2016 and the contract awarded to one prime provider, which in turn subcontracts to primary care

and voluntary sector providers. The current service is provided through four hubs, a number of spoke clinics, outreach, general practice, community pharmacies, and voluntary and community settings.

The prime provider is jointly commissioned and works to one contract signed by all seven commissioners, underpinned by a collaborative commissioning agreement between them all. The contract has a strong focus on prevention and includes an innovative series of 'service outcome related payment' objectives to reward delivery against specific strategic prevention outcomes. Governance is provided by a collaborative commissioning board chaired by a Stockton-on-Tees consultant in public health, and a key coordinating role is played by a contract manager based in the South Tees public health team. The new service has both improved access and achieved savings, and it is highly rated by users.

## Context

The four Teesside unitary authorities have a combined population of just under half a million. Stockton-on-Tees, the largest, has a mix of rural and urban areas, with one of the biggest housing estates in Europe. Middlesbrough, the next largest, is very urban and concentrated within a small geographical area. In contrast, Redcar & Cleveland is rural and spread out, with a coastline. Hartlepool, also on the coast, is more remote and the population tends to stay within the borough.

Teesside is served by two CCGs, Hartlepool and Stockton-on-Tees (co-terminous with the council areas) and South Tees (co-terminous with the boroughs of Redcar & Cleveland and Middlesbrough).

The population of the more rural boroughs is predominantly older, while Middlesbrough has a concentration of young people aged 20-29. There are significant levels of deprivation across Teesside. Although declining, teenage conceptions are high in all four boroughs, with rates in Middlesbrough and Hartlepool among

the highest in the country (at, respectively, 43.8 and 33.2 per 1,000 under-18s in 2017). Chlamydia detection rates vary, and in the two more populous boroughs they are below the national average as well as the (higher) Public Health England recommended 2,300 per 100,000. Rates of syphilis and gonorrhoea are steady or in some areas increasing. Although the rate of HIV late diagnosis is relatively high, diagnosed HIV prevalence is low at under two per 1,000 population.

Within Tees, there are significant flows of people accessing sexual health services across local authority boundaries for a number of identified reasons, such as closeness to their place of work and/or study, better transport links for some clinics, a strong desire for anonymity or reduced risk of being seen, and word of mouth or popularity of clinics.

## Sexual Health Teesside

### Objectives

The collaborative re-commissioning of Teesside sexual health services had the following objectives:

- to commission a high quality, integrated and seamless sexual health service across Teesside, with better access and more choice for the local population
- to commission collaboratively across the whole system to prioritise prevention, education and training, and services for young people
- to develop a highly trained and flexible sexual health workforce, able to move between boroughs and offer more targeted outreach sessions to different population groups
- to centralise and coordinate contact management, patient records and partner notification across Teesside
- to avoid the need for cross-charging between the four boroughs for residents using sexual health services across local authority boundaries
- to make a 7.4 per cent efficiency saving on sexual health service expenditure.

## Approach

Teesside first commissioned an integrated sexual health service in 2011. In 2013, as a result of the new division of commissioning responsibilities, the primary care trust (PCT) contract was disaggregated and novated into separate commissioning lines for each of the seven new commissioners – the four councils, two CCGs and NHS England's regional public health team. Recognising that separate commissioning could result in multiple providers and a fragmented system, and in view of the significant cross-border flow of people using sexual health services, the commissioners decided to collaborate to ensure continued delivery of an integrated service across Teesside.

With the councils having the greater burden of responsibility they commenced a major service review, followed by a re-procurement exercise. This was managed by the former Tees Valley public health shared service, which was managing the existing sexual health service contract. A review governance board, with membership consisting of the seven commissioners, was established to oversee the process. Stockton-on-Tees Council took on the lead role for procurement, including the provision of expert legal, financial and procurement advice.

The service review included a modelling exercise using three years of activity data to come up with a new tariff structure that would achieve a 7.4 per cent efficiency saving. A marketing company was commissioned to undertake a consultation exercise with a range of population groups, including young people, the findings of which informed the new service specification. A competitive tender was launched in 2016 and a bid from the existing provider was successful.

The contract is held by a prime provider which delivers sexual health services from four hubs, one in each borough, and several spoke clinics in the community, as well as through outreach. The prime provider has subcontracts with a number of GP practices across Teesside to deliver chlamydia screening, long-acting reversible

contraception (LARC) (implants and intra-uterine devices), and IUSs for heavy menstrual bleeding. It also subcontracts pharmacies to deliver chlamydia screening, emergency hormonal contraception and a 'C-card' scheme providing free condoms to young people. Further subcontracts with voluntary sector organisations include one for HIV prevention, testing and support for people newly diagnosed, one for education and outreach work with young people, and another for vasectomy services.

There is a single prime provider contract signed by all seven commissioners, with three separate service specifications for the elements commissioned by the councils, the CCGs and NHS England respectively. Every commissioner's contribution to the contract budget is stated and the provider invoices each of them directly. In line with recommendations from the service review and the health and wellbeing strategies of all the councils, the new contract has a strong focus on outcomes and prevention and includes six 'service outcome related payment' (SORP) strategic objectives. These are incentives, similar to NHS 'commissioning for quality and innovation' (CQUINS) payments, to reward the service for delivery against specific strategic outcomes.

A collaborative commissioning agreement signed by all seven commissioners sets out how they will work together to manage the contract throughout its term. A collaborative commissioning board, chaired by a Stockton-on-Tees consultant in public health with a sexual health lead role, brings them together for quarterly meetings to review contract and performance data and agree any changes required. There is also a service improvement forum, which includes the provider and sexual health leads from public health.

A contract manager, working in the joint public health team of Middlesbrough and Redcar & Cleveland councils, plays a coordinating role and acts as the liaison point through whom issues raised by any of the commissioners are discussed with the provider, and vice versa. Hartlepool Borough

Council offers pharmaceutical input and advice. Stockton-on-Tees Council took the lead role for procurement and also provides clinical advice through its consultant in public health on matters such as patient group directions and clinical governance. In this way, each council provides an 'in kind' contribution to contract management. During procurement, additional expert advice on nursing and safeguarding was provided by one of the CCGs, and on equality and diversity by Stockton-on-Tees Council.

The commissioning of an integrated service offers a number of benefits to the commissioners. With large numbers of people using sexual health services outside their borough of residence, the four councils avoid the need for mutual cross-charging, saving administrative costs. Further efficiencies and a better service for the local population are provided by centralised functions such as contact management, patient records and partner notification systems.

The new sexual health service delivers on a vision for the whole population of Teesside. Pathways are designed to be seamless, and users have a choice of appointments or walk-in clinics on an open access basis across the four boroughs. A full range of services is offered, including STI testing and treatment, chlamydia screening, HIV testing, HIV post-and pre-exposure prophylaxis (PEP and PrEP – the latter as part of the PrEP IMPACT trial), HIV support following diagnosis, human papillomavirus (HPV) vaccination, LARC and other contraception, vasectomy, IUSs for heavy menstrual bleeding, cervical screening and psychosexual counselling. Outreach services are delivered in schools, colleges and other settings for young people and groups at higher risk, and online services including STI testing kits have recently been introduced.

Through the sexual health contract, the NHS England regional public health team commissions opportunistic cervical screening, and the contract signatory is its cervical screening commissioner. A pathway to HIV treatment and care in the NHS acute

hospital infectious diseases department is part of the sexual health service contract, but HIV treatment and care are contracted separately by the NHS England regional specialised commissioning team. There is regular communication with the HIV specialised commissioner, who is copied into meeting minutes and was consulted on the development of the sexual health service specification. Antiretrovirals for HIV PEP and PrEP, and the HPV vaccine for men who have sex with men, are paid for by NHS England outside the contract and invoiced directly by the sexual health provider.

The CCGs, through the joint contract, commission vasectomy, psychosexual counselling and the fitting of IUSs for heavy menstrual bleeding. Although they commission abortion services separately through an independent provider, they collaborate with the councils to improve shared pathways. For example, faced with a recent increase in abortions – and the resulting costs – South Tees CCG is working with the local public health team to map areas with high proportions of abortions and increase contraceptive provision in those areas. The CCG's relationship with GPs and the local medical committee is helpful for the councils when seeking to increase provision of LARC in primary care, and the CCG's executive GPs act as champions with their peers.

Since 2011, the integrated sexual health service has been required to have a workforce trained in both GUM and contraceptive provision. All nurses are now dual-trained to provide a 'one-stop shop' experience: whether someone comes in for an STI screen or a repeat pill prescription, for example, the nurse they see can do both, as well as offering an opportunistic cervical smear. The service specification also requires the service provider to build capacity among community providers. Practice nurses undertaking degree courses (not funded by the sexual health service) in sexual health spend clinical time in the sexual health service to complete their competency training, and the service also provides training and supervision for doctors

and nurses to obtain Faculty of Sexual and Reproductive Healthcare (FSRH) Letters of Competence in LARC fitting, as well as annual contraception update sessions.

While primarily responsible for overseeing the contract, the public health leads help to broker partnerships with a view to shaping services and addressing health inequalities. For example, they participate in a pharmacy development group with the involvement of the local pharmaceutical committee, and they liaise with the CCGs, local GPs and the local medical committee, to support the development of pharmacy – and general practice-delivered sexual health services. Being based in local government, they have been well placed to help establish partnerships for sexual health outreach with youth services, drug and alcohol services and a charity supporting street-based sex workers. The provider also works closely with other stakeholders, for example the South Tees Maternal Infant and Child Health Partnership, and feeds back on this joint work in contract management meetings.

The public health directors across Teesside provided strong leadership and governance of the procurement process. One, in particular, was passionate that the service should remain Tees-wide and jointly commissioned. They approve any far-reaching decisions such as changes to service targets, further funding or moving clinics. However, because of the in-depth work carried out under their guidance prior to re-commissioning, there is rarely a need now for major strategic changes.

Within each council, the director of public health brings key decisions regarding procurement to the cabinet or executive. A number of councillors have provided valuable support. In particular, because the commissioning of clinical services was new and not necessarily well understood within local government at the time of transition, one public health portfolio holder played an important role as a sexual health champion with fellow councillors.

**“We wanted to work together with commissioning partners for a whole-system approach, where we would look at the population as a whole and the prevention agenda.”**

#### **Jacky Booth**

Contract Manager, Public Health  
South Tees, Middlesbrough Council  
and Redcar & Cleveland Council.

#### **Challenges**

The Tees provider market is small and there were few responses to the competitive tender. Joining up commissioners offered a higher contract value and a more viable contract for providers. In addition, awarding a five-year contract with the option of two two-year extensions avoided the necessity of another lengthy and costly re-procurement exercise in the near future, and made it more attractive for potential providers to bid. For the contract manager, the paucity of potential bidders highlights the importance of maintaining a good working relationship with the current provider, while still holding them to account. The directors of public health have considered whether, in the future, there might be other, more effective levers than competitive tendering.

Aligning the practicalities of procurement within all seven commissioning organisations, each of which had different processes and timelines, was complicated and time-consuming. Issues sometimes had to be escalated to a district lawyers' group (comprising solicitors from each council) or a procurement officers' group, and key decisions had to be steered through seven different high-level committees. A final element of delay arose in contractual negotiations with the provider, as NHS terms and conditions had been grafted onto a standard public health contract.



At the outset, 18 months was allowed for the service review and re-procurement but, in the end, it was necessary to extend the existing contract by five months. In retrospect, the contract manager feels two years would have been a more realistic timeline to aim for.

With CCGs facing a range of major commissioning challenges that necessarily took priority in 2013, they sometimes struggled to ensure the ideal level of consistency or seniority in their representation on collaborative procurement and contract management groups. This caused some frustration at times for the council representatives, but was understandable in view of their relatively small share of the contract. Ultimately, it did not undermine the collaborative agreement, which is still working well.

Confusion around payment arrangements for training presented a temporary barrier to skilling-up more GPs and practice nurses in LARC fitting. The prime provider was contracted to provide training and clinical supervision, but not to pay the necessary FSRH registration fees for primary care clinicians. After some initial misunderstandings, the CCG applied successfully to Health Education North East (HENE) for funding which enabled it to cover these fees. However, as a private, non-NHS organisation, the provider still faces difficulties accessing training structures set up for the NHS, such as securing HENE funding or becoming a recognised training provider for specialist doctors. A local solution for this is still being sought.

Documenting evidence of outcomes proved challenging. Despite performance that was probably satisfactory, the evidence submitted by the provider, who struggled to understand the commissioners' expectations, was insufficient to justify full payment of the SORP award. To resolve this, the contract manager worked with the provider to rewrite the reporting framework and negotiate a revaluation of some of the outcomes.

Similarly, the quality of the service has not always been reflected in the Public Health England dashboard indicators.

The provision of LARC by general practice under subcontract and without an FP10 prescription does not fit the current reporting options, so the provision of LARC was under-reported in Teesside for many years. The potential for amending the Sexual and Reproductive Health Activity Data Set data collection system has been discussed with NHS Digital and although they have not changed their data collection systems, there may be increasing pressure for this to happen as more councils develop novel commissioning arrangements.

Although performance varies between the councils, Teesside as a whole has struggled to hit Public Health England's recommended chlamydia detection rate of 2,300 per 100,000. The commissioners decided that holding the provider to account for delivery of an unachievable target was perverse and could distract from the achievement of other priorities. They therefore adjusted their contractual target to the national average of 1,900 per 100,000 (still challenging) and asked for more focus on other prevention priorities. It is now recognised that although mainstreaming chlamydia screening within the core sexual health service made sense, additional more focused work is also required, such as outreach and links with youth services, in order to achieve a higher detection rate.

The four councils each have different needs and priorities for their local populations and, where the provider has not been able to accommodate these, compromises have been achieved to maintain a single service. Currently, with the public health ring-fenced grant potentially about to be replaced by funding through business rates, the pressure on budgets may exacerbate the differences between the councils in terms of priorities or how to make further savings. While confident that agreement will be reached in relation to the sexual health service, the consultant in public health fears this combination of financial pressures and differing needs may make integrated contracts for other public health services less likely.

**“What you don’t want is a provider that’s pulled different ways by all the different commissioners. The contract manager is the key point of contact and has got that expertise.”**

**Jayne Herring**

Commissioning and Delivery Manager – Planned Care, NHS South Tees CCG

**Achievements**

Working collaboratively, commissioners in Teesside have managed to procure an integrated sexual health service for potentially nine more years. Despite shrinking budgets, the service is highly rated by users, consistently getting a high score on the ‘Friends and Family’ test and receiving positive feedback through a twice-yearly questionnaire. With the service operating across four boroughs, local residents have easy access wherever they are, and commissioners avoid having to make out-of-area payments for cross-border flows.

The inclusion of SORPs in the contract was an innovation to incentivise preventative work. It has enabled a greater focus on improving the sexual health of young people, including chlamydia screening, provision of young-people friendly services, access to contraception and outreach, and the prioritisation of HIV prevention.

The new service has improved access and achieved savings through relocation. The previous contract had designated specific NHS properties to be the four service hubs. These had high rental costs and, under the new contract, two hubs have been able to move into lower-cost council buildings. One of these, next to Redcar College, is much more convenient for users and has seen a 10 per cent increase in footfall since the move.

The Middlesbrough hub is re-locating to a building in the centre of town shared with drug and alcohol and mental health services, allowing greatly improved links with these organisations and on-the-spot referrals of their users to the sexual health service.

Teesside celebrates success by holding an annual sexual health conference, at which an award is offered to a person who has made an outstanding contribution to sexual health services. The conference attracts 100 people each year from a range of professional backgrounds and combines plenary sessions with practical workshops. The learning from Teesside’s collaborative commissioning has also been shared through presentations to meetings of public health directors across the region, facilitated by Public Health England.

**“We look at equity measures and monitor progress, not just at borough level but using universally shared outcomes.”**

**Edward Kunonga**

Director of Public Health, Public Health South Tees, Middlesbrough Council and Redcar & Cleveland Council

**Lessons learned**

It is important to allow plenty of time for a major service review and procurement, especially if undertaking this across several commissioning organisations. Experience from Teesside suggests two years is comfortable.

The service specification should be absolutely clear about the commissioner’s requirements, but not so prescriptive as to stifle innovation. The Teesside specification was very detailed to ensure nothing was omitted, but it was possible to balance this by including a schedule requiring the provider to set out proposals for innovation.

Appointing a single contract manager, working equally to the requirements of all collaborative partners, ensures that communication among and between commissioners and the provider is streamlined and consistent. The Tees contract manager is based in public health but has previously worked in the NHS, thus bringing an understanding of the different commissioners' requirements, as well as both the preventative and clinical dimensions of service provision.

Longer contracts can be beneficial for both commissioners and providers. In Teesside, a five-year contract with options to extend gave commissioners some security in the face of a small provider market, while the provider had more time to reap the rewards of investment in the bidding process and to allow innovations to become embedded in the service.

A joint service ensures better access for population across the whole area but can make it more difficult to respond to the needs of a particular locality or commissioning partner. In Tees, commissioners have made compromises regarding specific local needs in order to maintain the collaborative approach, but the requirement for further budget cuts places increasing strain on this arrangement.

**“An NHS understanding or background is helpful for monitoring and supporting quality, clinical governance and development of the service, but public health in the council can better support the preventative element of the service.”**

**Dr Tanja Braun**

Consultant in Public Health, Stockton-on-Tees Borough Council

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# Commissioning abortion and reproductive health in Lambeth, Southwark and Lewisham

A tri-borough sexual health commissioning team manages abortion contracts for three CCGs

“The manifesto commitments around reducing inequalities are central to many of the other workstreams that exist in Lambeth, so our work on abortion is very much a part of that.”

**Ruth Hutt**

Director of Public Health, London Borough of Lambeth

“The abortion contracts sit really comfortably with us because we look at sexual and reproductive health and HIV services as a whole, at entire service pathways, and understand that our residents access all of these services.”

**Jennifer Reiter**

Lead Commissioner – Sexual Health, London Borough of Lambeth, and on behalf of the London boroughs of Southwark and Lewisham

## Keys to success

- Joining up the commissioning of abortion and sexual and reproductive health facilitates an integrated response to the local population's needs along the whole reproductive health pathway.
- Public health involvement in abortion commissioning promotes exploration and understanding of the local factors underlying unplanned pregnancy and associated health inequalities.
- Locating the commissioning function within one council, on behalf of several councils and CCGs, provides efficiency savings and capacity to take a strategic focus on improving outcomes and saving costs.

## Outline

The London boroughs of Lambeth, Southwark and Lewisham have high rates of abortion, an indicator of unmet reproductive health need among their populations. A new joint sexual and reproductive health strategy seeks to address this by including, among its priority outcomes, reductions in reproductive health inequalities and unwanted pregnancies, and an increase in knowledge and understanding of reproductive health and fertility.

As part of a whole-system approach across the area, the tri-borough sexual health commissioning team, hosted by Lambeth Council, manages the contracts for abortion services on behalf of the three local CCGs. The team provides strategic oversight as well as contracting arrangements and regular service monitoring.

The commissioners use abortion service data to better understand the factors affecting local rates of unplanned pregnancy. Their findings feed into the reshaping of local prevention initiatives and contraceptive services to better meet the population's needs. Women in the three boroughs have access to a rapid and streamlined abortion pathway which includes a contraceptive offer, including long-acting reversible contraception (LARC), whether they have a surgical or early medical abortion.

## Context

The London boroughs of Lambeth, Southwark and Lewisham collaborate on sexual health commissioning and strategy development in order to use their resources most effectively to meet the significant needs of their populations. Their residents are predominantly young and diverse: the median age in Southwark and Lambeth is 33 and, in Lewisham, 35; 39 per cent are from an ethnic minority background, compared to 16 per cent nationally. There are high rates of, and persistent inequalities in, sexual and reproductive health need across the area, with young people, men who have sex with men, and black and minority ethnic communities the most affected.

The three boroughs have had significant success in reducing their teenage pregnancy rates. These remain relatively high at 24, 20.8 and 20.5 per 1,000 for Lambeth, Lewisham and Southwark respectively, compared to the London average of 16.4 (2017), but the decline since their peak has been dramatic and much steeper than the London or England average.

The most common forms of contraception used here are user-dependent (for example condoms or the pill), and this may contribute to high use of emergency contraception and abortion (including multiple abortions), particularly among women from black African and Caribbean ethnic backgrounds. However, increasing access to LARC is a local priority, and LARC prescribing rates (excluding injectables) are higher than the average for London at 47.1 per 1,000 resident women in Lambeth, 42.9 in Lewisham and 39.9 in Southwark (versus 34 for London).

This area has a history of innovation in sexual and reproductive health and HIV. It was one of the first to develop online STI testing, a service that has now been rolled out as part of the London Sexual Health Transformation Programme. More recent innovative developments have related to broadening the focus of young people's services and sexual health promotion, and piloting new ways of offering contraception, including online and postal provision.

## Abortion commissioning in Lambeth, Southwark and Lewisham

### Objectives

The commissioning arrangements for abortion in Lambeth, Southwark and Lewisham have the following objectives:

- to ensure that the local populations have rapid and equal access to high-quality abortion services
- to reduce reproductive health inequalities and unwanted pregnancies
- to join up council- and CCG-commissioned reproductive health pathways
- to achieve economies of scale and better population-wide data by commissioning across three boroughs.

## Approach

For over 10 years, Lambeth, Southwark and Lewisham have taken a coordinated approach to the commissioning of abortion services and other aspects of sexual and reproductive health. In 2013, when it became clear that abortion would not be part of local government's new public health commissioning responsibilities, the public health leads moving into the councils put forward the case to maintain the tri-borough links between all aspects of sexual and reproductive health, including abortion. This proposal was approved, and a commissioning agreement was established between the three boroughs and the three co-terminous CCGs, supported shortly after by a joint sexual health strategy.

A new five-year sexual and reproductive health strategy, launched in 2019, gives greater attention to reproductive health, with objectives including reductions in reproductive health inequalities and unwanted pregnancies, along with an increase in knowledge and understanding of reproductive health and fertility. The strategy states the critical role of access to safe, legal abortion, free from harassment, in protecting the reproductive health of women who choose to end a pregnancy. It also highlights the costs to the public purse of unwanted pregnancies, stating that contraception is extremely cost-effective and one of the highest value public health interventions, with LARC methods the most effective.

Lambeth Council hosts a team which commissions sexual and reproductive health services across the three boroughs and manages contracts for the three CCGs. Consisting of a lead commissioner and two whole-time-equivalent senior commissioning officers, the team also works strategically with primary care commissioning colleagues, as general practice and pharmacy are key providers of sexual and reproductive health services.

Abortion is one of the contracts the commissioning team manages on behalf of the CCGs. Each abortion provider has one rolling contract, jointly signed by all three CCGs and containing an indicative budget for each CCG. Payment is made by the CCGs for their residents based on activity. The commissioning team provides strategic oversight, reviewing the service specification and key performance indicators annually, updating these if necessary and working with providers to execute the contracts. It monitors the services and meets regularly with the providers to hold them to account.

Two independent providers between them provide 90 per cent of local abortions, and one NHS acute provider cares primarily for women with more complex co-morbidities. There has been no appetite to go out to procurement, as the providers have been well established locally for decades, work well together and provide high-quality services that receive exemplary feedback from service users.

The abortion pathway is modern and streamlined. One of the independent providers runs a central booking system, whereby women resident in the three boroughs can choose to go to any service in the country run by either of the two independent providers or, if medical issues dictate, they are booked into the local NHS service. The central booking system number is known by all relevant local professionals and can be easily found on the web. Women can self-refer and book an initial phone consultation, during which contraception is discussed, followed by an appointment for the abortion procedure (at which contraception and STI/HIV testing are also offered).

One of the independent providers is also currently running a contraceptive counselling pilot, in which a separate telephone session is held with the patient to discuss in detail the full range of contraception – answering women's questions and concerns, busting myths and giving them time to reflect on their contraceptive options and where they can access them, separate to the logistics of organising the abortion appointment.

The council commissioners have a good working relationship with the abortion providers, who value their sexual and reproductive health expertise and come to them for insight into current developments in the system which may impact on abortion services, as well as to coordinate public communications or suggest innovations. For example, in response to a halving in the rate of LARC fitting in abortion services as more women chose early medical abortion (EMA) (which does not require clinical follow-up, cutting out the opportunity for post-abortion LARC discussion and provision), one provider agreed with the commissioners to pilot and roll-out a post-EMA LARC service. This means that now, before taking away their EMA pills, women are offered an appointment to return for a LARC fitting at a later date, and subsequently receive reminder texts.

Every year a tripartite agreement details the governance arrangements for sexual and reproductive health commissioning across the three boroughs, and the amount of funding each council and CCG will put into the commissioning of services. (Initially, the council decided to absorb the commissioning team staffing costs because of the evident public health benefits, but more recently, with increasing financial pressures on local government, the CCGs have made a financial contribution to staffing.)

A sexual health commissioning partnership board provides oversight, with representation from CCGs and councils at assistant director level, meeting quarterly to receive performance reports. In addition, the commissioning team holds regular one-to-one meetings with each CCG to report on their contracts. A relationship of trust has been established between the CCGs and the commissioning team, whose monitoring of activity and finance enables them to provide forecasts to inform annual indicative budgets and give early warning of any likely overspend.

The public health teams use service user feedback and comprehensive data from the abortion providers, along with an annual demographic analysis, to seek a

deeper understanding of the factors behind unplanned pregnancies and patterns of behaviour in relation to abortion. For example, the data showed that a significant proportion of local women having an abortion had not been using reliable contraception, despite not wanting to become pregnant, and a number were choosing to remain without contraception after their abortion. Focus groups were organised with local women to explore their understanding of contraception and fertility, including cultural beliefs, and the impact of these on their behaviour.

Current innovations include a new pharmacy offer of emergency contraception and bridging oral contraception, sexual health services offering oral contraception by post, an online contraceptive method suitability checker and comparator, online ordering of oral contraception, and the development of a central booking system for LARC and emergency intrauterine device (IUD) fitting. The commissioners keep the CCGs informed about these developments, which should ultimately result in a reduction in abortions and costs to their budgets.

Lambeth sexual health commissioners participate in pan-London and south east London commissioner and provider groups that collaborate on strategic issues. One of these related to the development of 'buffer zones' around abortion clinics to protect patients and staff from harassment. After liaising with the first council to introduce buffer zones in London, Lambeth undertook local scoping, evidence-gathering and consultation around the potential for taking out a Public Spaces Protection Order.

At that time, the portfolio of the chair of the Lambeth health and wellbeing board included both public health and community safety. Already supportive of the sexual health team's work, the chair was able to broker connections for them with the council's community safety team and, although the need for buffer zones subsided, the resulting joint work between public health and community safety enabled mechanisms to be put in place in case the need arises again.

**“We have been able to engender an open relationship between councils and CCGs where we can share the challenges, they can come to us with questions, we anticipate their needs around budgets and outcomes and they trust us.”**

**Jennifer Reiter**

Lead Commissioner – Sexual Health, London Borough of Lambeth, and on behalf of the London boroughs of Southwark and Lewisham

**Challenges**

For CCGs, abortion is a relatively small area of expenditure and this can limit their capacity to focus on driving service improvement. Devolving the commissioning function to local government brings benefits on both sides, with the potential to improve outcomes and save costs. However, in view of their many priorities, keeping CCGs engaged can remain a challenge. In Lambeth, Southwark and Lewisham, making abortion part of a bigger devolved package of responsibilities exercised on behalf of the CCGs, including HIV care and support, makes it more significant and encourages greater engagement.

Working across three councils can be difficult, and across six organisations even more so. Trust in the commissioning team is important, but a key success factor here is that the partners, while devolving commissioning responsibility, remain engaged and actively part of discussions about service changes, especially at borough level. While each council values the benefits of the tri-borough approach, there is also a recognition of the need for localism, and it is accepted that the approach will not be uniform across the three boroughs.

One of the biggest challenges for sexual health commissioning is the financial pressure on councils, which has reached the point where Lambeth’s public health director believes it is not possible to “wring any more out of the system”. On the positive side, she acknowledges that lack of funds can spark creativity and acceptance of new models, and that certain beneficial aspects of service transformation would have taken much longer (or not even been considered) had they not been driven by financial necessity. Looking to the future, she would like to see more involvement of primary care in the coordination of sexual health provision, and the general medical services (GMS) contract funding received by GPs for basic contraception being used as part of the strategically planned local ‘pot’ for sexual health. However, as regards abortion, the location of its commissioning in CCGs goes some way to protecting its budgets while local government finances remain tight. As a medical service to which rapid access is critical, this protection is important.

While councillors in all three councils are supportive of local government taking a lead role on abortion commissioning, there is an awareness of the political sensitivity of abortion among some local communities. After initial consideration of budget pooling between CCGs and councils, it was decided that leaving the abortion budget with the CCGs would make it clearer that the councils’ role is not to directly commission abortion but to contract-manage it on behalf of the NHS.

Although there might be benefits if abortion were commissioned collaboratively across a wider geographical footprint, the priority is to ensure that it is commissioned in an integrated way with other aspects of sexual and reproductive health, which means maintaining tri-borough co-terminosity.



There are opportunities to address shared issues more informally through participation in the south east London sexual health service improvement and innovation steering group, as well as its local clinical advisory group. The emerging local place-based integrated care models have focused on community services, but sexual health has not been part of this discourse to date. Due to the open access nature of sexual health clinics, and the mobility of patients between services, working across a larger footprint and with other London boroughs has been the focus of joint working. However, there may be opportunities in the future to link neighbourhood-based care within the emerging primary care networks with wider reproductive health services, including cervical screening, contraception and HIV care.

Looking forward, public health teams face the challenge of trying to understand the impact of current changes to sexual health service provision on the population groups most likely to be affected by abortion. Specifically, what will the move to more online STI screening mean for women who might have sought face-to-face advice on contraception or abortion while at the clinic for STI services?

**“We get economies of scale, we get better services, and we can use our resources in terms of our expertise, capacity and capability much better across the three boroughs; but we have also recognised the need for more local approaches, which can be flexible and responsive to the needs of our local communities.”**

**Kirsten Watters**

Consultant in Public Health, London Borough of Southwark

## **Achievements**

The commissioning arrangements in Lambeth, Southwark and Lewisham have enabled the provision of a quick and efficient abortion service for residents across the three boroughs, designed to meet their needs. Despite high levels of deprivation, significant health inequalities and high numbers of unwanted pregnancies in all three boroughs, almost three-quarters of women obtain an abortion at under 10 weeks' gestation. For several years up to 2016, performance against this indicator was better than the England average (although, as in several other London boroughs, it dipped in 2017).

By commissioning abortion across three boroughs and analysing data submitted by three providers, sexual health commissioners and public health are able to build an overall population picture of the factors leading to unwanted pregnancy locally, and the characteristics of women who seek an abortion. Data on abortion also help identify areas of weakness in the contraceptive pathway. This informs the planning of prevention work 'upstream', as well as interventions within the abortion service to reduce multiple abortions.

Preventing unwanted pregnancies furthers the councils' priorities in relation to reducing inequalities and improving outcomes for children and young people. Abortion rates in the three boroughs are highest among women from black African and Caribbean ethnic backgrounds, and it is known that planned pregnancies have better outcomes for mothers, children and other family members than those that are unplanned. Within councils, public health leaders have been able to gain traction for arguments to improve access to contraception and abortion by framing them in terms of their impact on family overcrowding or children being taken into care. Being located within local government also helps public health teams to prioritise early intervention by making links with schools and youth services.

“If you just talk about sexual health, people don’t feel it’s that relevant to them, but if you talk about overcrowding, children being taken into care, repeat pregnancies for women who have other vulnerabilities and the impact that has on our wider system, then people are interested.”

**Ruth Hutt**

Director of Public Health, London Borough of Lambeth

### **Lessons learned**

By commissioning collaboratively, councils can gain economies of scale and better drive service improvement. In Lambeth, Southwark and Lewisham, the sexual health commissioners have a stronger voice because they negotiate on behalf of three boroughs, and they benefit from population-based data across a wide geographical footprint.

Joining up the commissioning of sexual and reproductive health and abortion services creates a virtuous loop. Understanding gained from commissioning abortion informs the reshaping of local sexual and reproductive health services, while understanding of the sexual and reproductive health system informs the commissioning of a comprehensive abortion service, both with the aim of improving sexual health and wellbeing, reducing unwanted pregnancies, and saving associated costs to the NHS and local government.

The involvement of public health specialists in commissioning can bring better outcomes than relying on a more purely contractual commissioning model. In the tri-borough approach, public health teams analyse and build on data reported by service providers to better understand and address the factors driving demand for abortion, including the wider societal determinants which lead to inequalities in reproductive health outcomes.

Devolving the management of abortion commissioning to local government without devolving budgets provides multiple benefits. The sexual health commissioners here have the knowledge and capacity to commission abortion services proactively, providing feedback to the CCGs as needed, while the retention of ultimate commissioning responsibility within the NHS offers some protection from political sensitivities and erosion of public health budgets.

Council portfolio holders and other councillors can play a key role as local champions for women’s reproductive health rights. In Lambeth, the joint portfolio holder for public health and community safety was instrumental in helping to develop plans to protect service users and staff from harassment outside abortion clinics. Other councillors provided encouragement and political support for the council’s officers who were managing this sensitive issue.

“We’re really lucky because other commissioners of abortion services don’t have that landscape view of what’s going on in sexual and reproductive health, in primary care, in young people’s services, in schools, where women are accessing contraception or not, and how are they finding out about services.”

**Jennifer Reiter**

Lead Commissioner – Sexual Health, London Borough of Lambeth, and on behalf of Southwark and Lewisham councils

“The risk is that commissioners in local authorities have no idea about what’s happening with abortion as it’s not something they are involved in, so they are missing information about one of the primary outcomes of contraception.”

**Ruth Hutt**

Director of Public Health, London Borough of Lambeth

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# Integrating contraception into the maternity service in Gloucestershire

An integrated care system (ICS) pilot

“At its most basic level it’s about drawing up pathways for women, making things easier for people and tackling inequalities.”

**Sarah Scott**

Director of Public Health, Gloucestershire County Council

“This was a really good example of how you can drive things forward through the ICS by cutting across boundaries – not trying to compartmentalise the outcomes to the NHS, or to social care or to something else, but talking about how it impacts on the health of the population and the outcomes and activity within the wider system.”

**Dave Mc Conalogue**

Consultant in Public Health, Gloucestershire County Council

## Keys to success

- An ICS can provide a framework for councils, CCGs and NHS providers to commission innovative public health approaches in partnership, and to assess their impact across the whole system.
- Building robust evaluation into the design of experimental new service models is key, in order to provide the evidence base to support longer-term funding.
- Enabling clinicians to play a lead role in designing new pathways within their own service will generate workable solutions and foster enthusiasm among the workforce to implement them.

## Outline

Gloucestershire County Council worked with partners in the integrated care system (ICS) to develop and pilot an integrated and comprehensive contraception offer in maternity services. The key partners were the council, the maternity services, the CCG and the specialist sexual health service. The focus was on women with vulnerable characteristics who are more likely to have an unplanned pregnancy and least likely to have contraception in place during the weeks following delivery (a high-risk period), and who have the worst outcomes from unplanned pregnancy (for them and their family unit).

The model was characterised by its integration within the maternity service, with contraceptive advice and provision being undertaken by midwives in the community midwifery service and the hospital delivery suite. Initial results from the service, launched in November 2018, show that it is effectively targeting women identified as having a vulnerability: 100 per cent of eligible women were engaged in a discussion about contraception needs, 97 per cent of those made a plan for contraception, and 85 per cent of women had their chosen method of contraception administered through the maternity services team.

## Context

Gloucestershire County Council serves a population of over 600,000, with two urban hubs – Gloucester and Cheltenham, a number of smaller towns, and a large rural area. The population is reasonably affluent and ageing but there are quite stark inequalities, with some urban areas in the top 10 per cent for levels of deprivation. The council has the advantage of being co-terminous with the CCG and other public bodies and is part of the Gloucestershire ICS. Maternity services in Gloucestershire are provided by Gloucestershire Hospitals NHS Foundation Trust, with an obstetric-led delivery suite in Gloucester and midwifery-led birthing units in Gloucester, Stroud and Cheltenham.

The rate of under-18 conceptions in Gloucestershire is 14.8 per 1000 women aged 15-17, similar to the South West region average and below the England average of 17.8. The repeat abortion rate in under-25s dipped in 2017 to 14.2 per cent, lower than both the regional (22.1 per cent) and England (26.7 per cent) averages. The rate of prescribed LARC (excluding injectables) is relatively high at 74.2 per 1000 women aged 15-44, compared to the averages for the region (64.0) and England (47.4).

## The 'Preventing Unplanned Pregnancy' pilot

### Objectives

The 'Preventing Unplanned Pregnancy' pilot aimed to:

- give vulnerable women control over their fertility at a high-risk time by integrating contraceptive advice and provision into the maternity service
- reduce the negative outcomes associated with unplanned pregnancies for vulnerable women and their families
- evaluate the effectiveness and system-wide return on investment from an integrated maternity contraception model.

### Approach

A Gloucestershire audit of around 100 vulnerable women who went through the maternity contraception pathway (for example, teenage parents and women with mental health, substance misuse or safeguarding issues) found that only about a quarter of their pregnancies were planned. This compares to around 55 per cent of pregnancies in the general population. Unplanned pregnancies are more likely to result in abortions, shorter intervals between births and children entering the care system, with those who are most vulnerable most likely to have the worst outcomes.

The public health team in Gloucestershire recognised that the six-week period following childbirth can be a particularly risky time for unplanned pregnancy. This is especially the case for teenage parents and women with chaotic lifestyles or other vulnerabilities. However, it is also a time when women are very engaged with healthcare services, in a way that more vulnerable women may not normally be. The period before delivery, when women are engaged with maternity services, is therefore a key opportunity to discuss contraception needs and to support women to take control of their fertility.

For some time, attempts had been made in Gloucestershire to improve women's access to contraception during this window of opportunity. Contracts with the specialist sexual health service had allowed for a small payment to cover staff visits to the postnatal ward to offer contraceptive advice when requested by the midwives. However, this had not worked well, with women rarely leaving maternity services with a chosen method of contraception in place. Midwives were frustrated to see women returning with repeat unplanned pregnancies, and reported that their patients wanted to be able to access contraception within the maternity service.

The emergence of the Gloucestershire ICS was the opportunity to bring together partners from the council's public health team, the CCG, the NHS hospitals foundation trust and the specialist sexual health service (provided by an NHS community trust) to find a solution. To further the aims of the sustainability and transformation plan, the CCG had put forward £1.9 million for a prevention and self-care fund to provide pump-priming money for innovative pilot projects and assess whether they would deliver a return on investment. The public health team submitted a business case to develop and evaluate an integrated maternity contraception model with a strong focus on more vulnerable women, and funding was agreed.

Gloucestershire County Council also committed half of the funding for this pilot, and a small contribution was made as part of the prevention workstream of the 'Gloucestershire Better Births Programme', a local transformation plan set up by the CCG to meet the outcomes of the 2016 national maternity review. The CCG's lead commissioner for the programme at the time held a joint council/CCG post and worked closely with public health.

Armed with £200,000 of funding over two years and an approved concept, the public health team approached the divisional director of maternity services at the hospitals trust to secure her support, then held a meeting with members of the maternity service

management, a consultant obstetrician, the lead midwife and other members of the midwifery team. They asked them to work in partnership to develop a model of integrated maternity contraception provision for vulnerable women. The starting parameters were loose – the public health team wanted women to come out of maternity with a method of contraception based on their own choice, and they suggested an approximate number of women to be included, but the maternity staff were given scope to develop the service model. The invitation to work in partnership was accepted.

A steering group was set up to develop the service specification, with membership mostly drawn from public health and the maternity service, as well as a representative of the specialist sexual health service. There was also sporadic attendance from a range of other midwives throughout the development. Despite wider interest in the pilot, for example from Public Health England and NHS England, it was decided to limit the membership of the steering group at the developmental stage, to enable the midwifery team to feel in control and build up its confidence.

The group's work was informed by evidence reviews on women's attitudes to contraception and existing models of contraception provision. While the review found no fully integrated maternity-based contraception services in the UK, learning about such projects operating successfully with much less resource in developing countries gave the team confidence. The group mapped the current maternity and contraception pathway then held a workshop with about 40 people from maternity and sexual health services, public health and the CCG to go through this and plan the future pathway.

Opting to avoid a model whereby sexual health specialists came into maternity services to provide contraception, as had been tried before in Gloucestershire and elsewhere, the steering group decided that contraception advice and provision would be provided by midwives in both the community midwifery teams and the delivery suite.

As part of the regular maternity pathway, women would be engaged in a conversation with a midwife, who would give them information about contraceptive options and help them make an informed choice. The maternity service would also administer the chosen contraceptive method before women left the service after giving birth, or at the latest in the few days that followed. Rather than delivering contraception, the sexual health service would be a key partner, providing advice, guidance and training to the midwifery teams.

The council used a Section 76 agreement to commission the service through the CCG, which already had a contract with the Gloucestershire provider of maternity services. The provision of advice and training for the pilot was included in the council's contract with the newly re-commissioned sexual health service.

After a period of training, the integrated contraception service started in November 2018 in Gloucester. Two midwives took on the role of specialist contraception midwife, sharing a whole-time-equivalent post. Their role is primarily to offer mentoring and support to the other midwives. The sexual health service advised on the training and qualifications required for these posts and provided a one-day basic contraception training session for about 35 midwives, enabling them to give prescriptions for oral contraception, provide Depo-Provera injections and administer condoms.

Several midwives also underwent training to obtain the Faculty of Sexual and Reproductive Healthcare (FSRH)'s Letter of Competence in the fitting of sub-dermal implants, while three opted to obtain the FSRH Diploma. The supervision and observations required for these qualifications were provided by the sexual health service.

The pilot's budget was used to pay for the specialist contraception midwife post and for training of midwives, including backfill for their attendance.

There was no additional resource to pay for the actual provision by staff of the contraception pathway, but the midwifery team were so enthusiastic and committed to the new model that they were happy to absorb this within the service. The contraceptive drugs and devices were paid for by the council as part of the service.

User feedback informed the pilot throughout. Once the pathway was mapped out, some of the tools were tested with women using the service. An evaluation is now underway, with anonymous surveys of over 100 women who have had the opportunity to go through the new pathway, and with staff from the midwifery and sexual health teams. As well as guiding ongoing improvements to the service, the results of this will form the basis of a business case for longer-term funding. They will also be of interest to colleagues in other parts of the council, particularly children's services.

The lead partners in the pilot are the maternity and public health teams, which together shaped and implemented the new pathway, with support from the CCG and the specialist sexual health service. The sexual health service played an active and facilitative role from the start. The CCG commissioner, while less actively involved, was a key backer throughout, and will be fully engaged in putting together the business case for new funding.

At a higher decision-making level, Gloucestershire's Joint Commissioning Partnership played a key role. Its executive comprises the council's directors of public health, adult services, children's services and finance, the CCG's accountable officer and director of finance, and a director of integration who leads the commissioning of a £200 million aligned budget between the council and CCG. This group meets monthly and is a powerful means to get things done and resolve problems across the system, including finding ways to share and mitigate the impact of public health budget cuts. It created the prevention and self-care fund and awarded part-funding to the maternity contraception pilot, based on the public health director's recommendation.

The partnership's upper tier, the joint commissioning partnership board, operates under the health and wellbeing board, and both are chaired by the same councillor.

**“We developed the service specification with maternity services in partnership, then commissioned it through the CCG using a Section 76 agreement.”**

**Dave Mc Conalogue**

Consultant in Public Health,  
Gloucestershire County Council

### **Challenges**

There was a potential risk of the project being seen as trying to stop disadvantaged women from having babies or to force them to use LARC. The initial business case included data on the cost-effectiveness of LARC, along with information from modelling about the impact of contraception on women's health and wellbeing, their existing children and families, and NHS and social care services. As children born to vulnerable women often need health and social care input, the case for return on investment was not difficult to make, but it was important to state clearly that the project was primarily about giving women control and choice, providing information and a space for them to make their own decisions about contraception, whatever those decisions might be. The team developed clear communication lines on this very early in order to manage the narrative.

A forthcoming challenge will be to secure longer-term funding. There is no clarity regarding the future of the public health grant, and NHS budgets are tight. Evaluation was built into the pilot from the outset to either prove that the service model works, or that it doesn't and should not be commissioned. If the former, the business case will need to present an irresistible evidence-based proposition for both council and CCG commissioners. In anticipation, the public health team have already been sharing

early data and anonymised individual case studies (with service users' permission) to raise awareness of the project and enable commissioning partners and other key decision-makers to understand the impact it is having on individuals. This communication is important, as the case for investment of the 'Gloucestershire pound' needs to be made to the whole system, focusing on improving health and wellbeing outcomes for the local population, especially its most vulnerable members. The director of public health has a key role to play in this communication.

The pilot took longer than expected to get up and running because time was needed to consider the appropriate model in genuine partnership with the maternity service. Initially, a cautious approach was suggested by public health, involving sexual health specialists coming into the maternity service, but the midwives did not believe this would work and argued for midwives themselves to become the specialists. Once the decision was made to pursue this idea, everything changed and the project moved forward. The consultant in public health is glad they took the time to get it right, but wishes they had been braver sooner and started with the midwives' proposal.

There were concerns at first among funders, and among staff in the delivery unit, that midwives would not have time to speak to women about contraception. However, after they had undertaken training and started to provide the service, it became apparent that this fear had in fact been masking an anxiety about lack of knowledge. Once they had developed confidence through learning and practice, the midwives became extremely motivated because they saw the positive impact of their interventions.



**“We know there are long-term health, wellbeing and financial implications associated with unwanted pregnancies, for example a child may go into care, so there’s lots of benefits to thinking about things in a broader sense and collaborating with colleagues, and really involving clinicians in designing the way that services work”.**

**Helen Ford**

Integrated Care System Lead for Children’s Mental Health and Maternity, NHS Gloucestershire Clinical Commissioning Group

### **Achievements**

Performance data based on 92 women who have completed the pathway show that the service is effectively targeting women with a vulnerability (a range of vulnerabilities were identified, but notably 66 per cent had a safeguarding issue). Only 24 per cent had planned their pregnancy, which supports the focus on these women. The data showed that:

- 100 per cent of eligible women were engaged in a discussion about their contraception needs before delivery, and 97 per cent of those made a plan for contraception
- 85 per cent of women had their chosen method of contraception administered through the maternity services team
- 42 per cent of women received a Depo injection or sub-dermal implant (LARC methods).

The proportion of women receiving LARC methods is increasing rapidly as more midwives became trained to administer them. As the most effective and cost-effective type of contraception, the return on investment is higher for LARC than for other contraceptive methods. While the public health and midwifery teams were very clear that the maternity

contraception project was not set up to push women into using LARC, the midwives found that when women are presented with the option, understand its benefits and have easy access, LARC will most often be their method of choice.

This pilot project has helped to raise the importance of contraception and choice with midwifery teams outside the pilot group, who are also starting to support the women they care for in the wider population to access contraception.

Alongside the county council’s contribution, the prevention and self-care fund enabled the pilot to be jointly funded and owned by the council, the CCG and the clinical providers. Its strength comes from its position within the joint commissioning governance processes, which means that innovative ways of working can be found and tested out anywhere in the system and the benefits assessed across the system. It is a testament to the strength of relationships in Gloucestershire that the CCG, as well as the county council, puts money into prevention, and the council-based director of public health recommends how it should be allocated.

The maternity contraception pilot is a good demonstration of delivery of a public health initiative in a clinical service. For the director of public health, it is an excellent first step towards embedding health improvement approaches in the work of the acute trust, as recommended in the NHS Long Term Plan.

**“The strength of our relationship with the CCG is down to the fact they are very prevention-focused. They’ve allocated prevention funding for three years now, and that’s fantastic at this time when the public health budget is really, really stretched.”**

**Sarah Scott**

Director of Public Health, Gloucestershire County Council

## Lessons learned

Joint commissioning structures and governance enable public health initiatives to be assessed and valued for their impact across the system. The Gloucestershire Joint Commissioning Partnership executive recognised that the maternity contraception pilot, while based in a clinical service, had the potential not only to reduce unplanned pregnancies and abortions, but also to avoid wider social care costs, reduce inequalities, and help women, children and families to live better lives.

To develop a new model in partnership, it is important to be explicit and open from the outset about the parameters and the vision, and stick to those throughout, while accepting the sharing of control and welcoming the expertise and enthusiasm of partners. The Gloucestershire public health team were clear about their intended outcomes for the local population, but it was only when they gave up their pre-conceived ideas about the appropriate service model, and the midwives were able to shape the model for themselves, that a successful solution was found.

Sharing the good news early can 'warm up' decision-makers. The public health team has kept commissioning partners informed about the maternity contraception pilot, so they understand what it is and can consider how it fits with their future planning before they are presented with a business case for new funding. In this context, while statistics are helpful, the stories from midwives about individual women in difficult circumstances can be more compelling.

The ICS facilitates a public health leadership role across the system. Gloucestershire's director of public health describes her role as 'spotting an opportunity and knitting things together strategically,' and in this she is supported by powerful relationships through the ICS, not only within local government and the NHS but also with other statutory bodies who work for the local community, such as the police.

**“Now we are an ICS, so we talk a lot in the leadership team about the ‘Gloucestershire pound’ – how will this benefit the whole system. It’s about health and wellbeing outcomes rather than just health outcomes.”**

### **Helen Ford**

ICS Lead for Children’s Mental Health and Maternity, NHS Gloucestershire Clinical Commissioning Group

**“The pilot has been a joy to work on – the sort of thing where you forget about the difficult bits. It’s not been easy, but the approach that we’ve taken and the enthusiasm we’ve had has made various obstacles relatively easy to overcome.”**

### **Dave Mc Conalogue**

Consultant in Public Health,  
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# Population-based cervical screening in sexual health services across Cheshire and Merseyside

NHS England collaborates with nine local authorities

“There is a call in the NHS Long Term Plan to find more ways to join up the commissioning of public health services – this is a prime example of what we can do together.”

**Ian Ashworth**

Director of Public Health, Cheshire West and Chester Council, and Lead Director of Public Health for Sexual Health for Cheshire and Merseyside

“Ensuring that access to cervical screening was maintained for women in Cheshire and Merseyside was our collective priority. This work has achieved this and is an excellent example of joint commissioning.”

**Julie Kelly**

Head of Public Health, NHS England and NHS Improvement – North West

## Keys to success

- Collaborative commissioning is facilitated by established relationships of trust and open communication, along with shared goals.
- Public health leaders across the system in different commissioning organisations play a key role in identifying ways to join up commissioning and service provision for the benefit of local populations.
- Despite funding pressures, investing in additional dedicated resource to drive transformational change is essential.

## Outline

Nine local authorities worked with NHS commissioners to develop a common specification for sexual health services across Cheshire and Merseyside. An early win from this collaboration was an agreement with NHS England’s regional public health commissioners to maintain and standardise arrangements for cervical screening within sexual health services. Since the re-organisation of commissioning arising from the Health and Social Care Act 2012, NHS England has had responsibility for cervical screening programme commissioning.

Screening data and insight research showed that some women were choosing to use sexual health services for planned cervical screening appointments, while others were being offered opportunistic screening in those settings. However, there was a risk in the current round of sexual health re-procurements that cervical screening would be excluded from some new providers' contracts. Concerned about declining national screening rates, the nine public health directors and the regional NHS England head of public health agreed on the importance of maintaining access and choice, and took leadership to find a collaborative solution.

NHS England agreed to fund sexual health services to provide up to 10 per cent of all local screening activity. A requirement to provide cervical screening under contract with NHS England was written into the councils' common sexual health service specification, to be included in all local procurement documentation. Separate contractual arrangements were made directly by NHS England with providers, specifying screening mechanisms and funding details.

## Context

The nine councils in Cheshire and Merseyside – Cheshire East, Cheshire West and Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington and Wirral – work closely together on public health. The Cheshire and Merseyside health economy has a varied demographic profile, with pockets of extreme deprivation within each local authority area but also significant areas of affluence. There are sexual health inequalities between councils across the patch, broadly mirroring the pattern of deprivation.

Coverage of cervical screening has been declining nationally and is at a 20-year low, having dropped to 71.4 per cent in 2018.<sup>12</sup> In the North West of England (including Cheshire and Merseyside), coverage in 2018 was close to the national level at 71.8 per cent<sup>13</sup>, which fails to meet the overall screening coverage target of 80 per cent. Between 2014 and 2018, cervical screening samples taken in sexual health services nationally fell by 52 per cent<sup>14</sup>, despite evidence that women screened in these services are at greater risk of cervical cancer. The decline in in the North West was smaller than nationally, but still large at 38 per cent.

Cheshire and Merseyside has a strong tradition of collaboration in public health and sexual health. The Cheshire and Merseyside Public Health Collaborative (CHAMPS) works across the nine council areas with the support of all the public health directors, who meet regularly. Each of them leads on a particular topic, of which one is sexual health. All the sexual health commissioners regularly meet as a peer group to look at areas of common interest.

In 2017 the area was picked for a national pilot project, overseen by Public Health England, which aimed to explore ways in which the fragmentation of sexual health commissioning arrangements could be countered through a whole-system, collaborative commissioning approach. Although there was no additional resource for the pilot, a part-time programme lead based within CHAMPS was jointly funded by the councils to support and drive the process.

12 Public Health England (PHE) Screening blog: 'PHE to launch national cervical screening campaign in March 2019' (30 November 2018).

<https://phescreening.blog.gov.uk/2018/11/30/phe-to-launch-national-cervical-screening-campaign-in-march-2019>

13 NHS Digital: 'Cervical screening programme, England, 2017-18' (27 November 2018).

<https://files.digital.nhs.uk/B1/66FF72/nhs-cerv-scre-prog-eng-2017-18-report.pdf>

14 Jo's Cervical Cancer Trust: 'Computer says no. The growing issue of access to cervical screening across the UK: the problems and how they can be overcome' (June 2018). [www.jostrust.org.uk/sites/default/files/final\\_accessibility\\_policy\\_jun2018.pdf](http://www.jostrust.org.uk/sites/default/files/final_accessibility_policy_jun2018.pdf)

# Commissioning population-based cervical screening in sexual health services

## Objectives

Collaborative commissioning arrangements for cervical screening in sexual health services were established to:

- maintain and increase levels of cervical screening coverage across Cheshire and Merseyside
- ensure that all women participating in the national cervical screening programme across Cheshire and Merseyside continued to access a choice of providers
- provide equal access to cervical screening across Cheshire and Merseyside
- use public health and NHS budgets in a complementary way for optimum outcomes and maximum efficiencies.

## Approach

Since 2013, NHS England has had commissioning responsibility for the national cervical screening programme as part of the public health functions agreement (Section 7a). Cervical screening does not fall within the scope of local government's sexual health commissioning responsibilities. However, as part of legacy arrangements inherited by individual councils, cervical screening remained in most of the sexual health contracts across Cheshire and Merseyside. This reflected longstanding practice within the services, some of which were providing opportunistic screening (offering a 'smear' when women attended for other sexual health needs), while others were also running pre-booked screening clinics, sometimes taking referrals from GPs.

The new division of commissioning responsibilities led one of the nine councils, in procuring its new sexual health service, to remove opportunistic cervical screening from its contract. This prompted a decision from NHS England to make alternative arrangements, as the removal of cervical screening from sexual health services would

reduce access to screening. In the face of declining uptake of cervical screening, NHS England and council commissioners were determined to avoid reducing access purely because of new demarcations in commissioning responsibilities. They agreed that a joint solution was needed.

NHS England public health colleagues met with the public health directors of the nine councils to discuss the challenges and complexity in commissioning arrangements. NHS England requested data from the cervical screening call and recall service, which demonstrated that in seven of the nine areas, less than 10 per cent of all cervical screening activity took place in sexual health services. In the other two, activity levels were higher but this seemed to be for largely historical reasons. Although these numbers were relatively low overall, they were still delivering a service that they were not formally commissioned to deliver.

In addition to the cervical screening data, NHS England conducted some insight research with women across Cheshire and Merseyside attending sexual health services for cervical screening. This revealed a variety of reasons for choosing this setting, including ease of access, longer opening hours and being directed there by their GP. Many had come in response to the national screening programme invitation letter which offered this option. When asked about their preferred choice of setting, around two-fifths stated a preference for sexual health services over general practice.

In order to maintain women's choice and make cervical screening as easy as possible, NHS England was keen to retain provision within sexual health services. It agreed, based on its activity data, to fund sexual health services to provide a maximum of 10 per cent of each council area's total cervical screening activity. Initially, it was decided that NHS England would work with each of the nine councils individually to decide how the agreement would be implemented.

However, this work progressed slowly, complicated by each council being at a different stage of procurement and having different expectations and requirements.

Meanwhile, the public health directors were considering how to manage the broader fragmentation arising from the Health and Social Care Act – which had resulted in disjointed commissioning and service provision; a severe administrative burden on councils from cross-charging; unintended negative consequences of re-commissioning (or de-commissioning) services from providers whose workforce was delivering both NHS- and council-commissioned care; and above all, variations in service quality for local residents.

Many of the nine councils were in the process of, or about to start, re-procuring their sexual health services. In the face of year-on-year reductions in the public health grant, all were trying to achieve innovation and efficiencies and give more focus to prevention. As one of a number of joint actions to address these concerns, the councils decided to develop a common sexual health service specification, derived from the national specification, for use across the sub-region. This was part of a whole system approach, with the specification setting out how council-commissioned services would link to those commissioned by the NHS, in order to ensure consistent and integrated provision for their local populations without gaps or duplication. For reasons of feasibility, it was agreed the specification would be used for individual council procurements rather than attempting to co-commission a single Cheshire and Merseyside service, although one pair of councils did decide to use it for a joint procurement.

Local workshops were held with commissioners across the system to scope what should be included in the specification. This process coincided with the work already started by NHS England described above. The head of public health at NHS England North West suggested including cervical screening in the common specification and offered to work with the councils to achieve this.

Following high-level liaison by the lead director of public health for sexual health with councils and CCGs, new collaborative commissioning arrangements were agreed. As a result, a section was included in the councils' common service specification stating that the provider, by signing a contract to deliver the sexual health service, would also be agreeing to deliver cervical screening commissioned by NHS England. This standard wording now forms part of the procurement documentation for every local sexual health tender.

Most of the councils agreed that a direct contractual arrangement between NHS England and each provider would be simplest, thus avoiding the need for cross-charging arrangements. Most providers already had an existing NHS England contract for which an addendum, based on the national cervical screening specification, was sufficient. Each provider was awarded funding equivalent to 10 per cent of total screening activity in the local authority area, for a local tariff and paid upfront at the beginning of the year (regular activity-based invoicing being too labour-intensive for the relatively small sums involved). A small minority of councils preferred to include cervical screening in their own contract with the provider, receiving the up-front funding from NHS England themselves and, in turn, being invoiced by their providers.

While specifying the mechanics of screening and reporting, NHS England took a flexible approach to service delivery, allowing providers to design this based on local needs. As well as including cervical screening in regular clinic services, some providers have made it part of outreach services targeting specific vulnerable groups, such as a women's health day in a drug and alcohol service or a sexual health service for women in secure units. In view of the insight findings, NHS England's preferred approach was for each provider to offer a mix of opportunistic and pre-booked screening.

Depending on the stage of local procurement, it was sometimes necessary to agree that only opportunistic screening would be offered at first; but once procurement had been completed using the new shared specification, the providers were always required to deliver pre-booked screening as well.

NHS England will review activity yearly with each provider based on their data return. If the level of activity in any local authority area approaches the agreed ceiling, the provider is expected to discuss this with NHS England to ensure that the reasons behind it are understood. NHS England recognises that cervical screening cannot be allowed to dominate the sexual health service, and there is no expectation this would take over from screening provision in primary care. Both the NHS England and council contracts with providers include a simple key performance indicator for cervical screening. To reduce the reporting burden, NHS England has agreed to give screening data updates to the council commissioners so that performance can be monitored at their regular sexual health contract monitoring meetings, rather than setting up separate monitoring arrangements.

In view of current pressures on primary care, the possibility of GP federations subcontracting some of their screening workload to sexual health services has now been raised in one area. From the NHS England point of view, the priority is to ensure that local women continue to have a choice of provider.

It is too early to say whether the new arrangements have had an impact on local screening rates, as 2018/19 will be the first year to generate a full set of annual activity data in most council areas. However, as the initiative has coincided with the launch of Public Health England's national multimedia campaign to promote cervical screening uptake, it may be difficult to know to which of these any future increase should be attributed.

**“We should be proud because we’ve got nine local authorities on board and we have along the way overcome all these barriers, but actually it was about just getting everybody round the table together and saying ‘this needs to work’.”**

**Helen Dickinson**

Public Health Programme Manager, NHS England and NHS Improvement North West

### **Challenges**

There was a mismatch between activity-based funding arrangements in use for level three (specialist) GUM services and the new cervical screening contracts. The GUM tariff included a fee for each first appointment, so appointments for cervical screening still attracted council funding as well as the NHS England contribution. In addition, with mandated open access, there was considerable cross-border flow of service users. While not a major problem for NHS England, whose budget is for screening across a wider geographical footprint, this threw up the need for cross-charging arrangements between council commissioners. This discrepancy will disappear for those councils whose re-procurements include a move to an integrated sexual health function incorporating service levels one, two and three with block funding.

While the need to maintain cervical screening access was recognised by all, the differences between councils in the timing and nature of procurements made it hard initially for NHS England to engage with all the commissioners. For example, in one area the sexual health service had just been re-procured (without cervical screening in the model) and there was a reluctance to create disruption. In another, the existing provider did not have the capacity to take on cervical screening. However, the commissioners from across the system coming together with a shared objective and agreeing to put

cervical screening into the common service specification put out a strong message that this was everyone's business. Progress was also facilitated by NHS England's flexible and staged approach, its development of a limited number of contracting options for each council to choose from, and the standardised wording created for procurement documents and contract variations.

Year-on-year decreases in the public health grant have placed enormous pressure on public health directors and their teams. Each council has faced different constraints with little room for manoeuvre, making it a struggle to negotiate common, consistent approaches between councils. However, the extra attention given to collaboration by being part of a national pilot, plus the development of a common service specification and the standardised approach to contracting arrangements, enabled a successful solution to be found for cervical screening in sexual health services.

**“Every opportunity to engage a woman in the cervical screening programme has to be acted upon. And if we say to the service, ‘you can't do it because you're not commissioned to do it’, the only person that's losing out is the woman in question.”**

**Simon Bell**

Public Health Commissioning Manager and Programme Lead for Sexual Health, Halton Borough Council

**Achievements**

The collaboration between councils and NHS England on cervical screening has fostered a much better understanding among all commissioners of how the parts of the system work together. The sexual health commissioners liaised closely with each other through their regular forum and the role of the public health directors was key, in particular their lead for sexual health, in sitting down with NHS England, reviewing the evidence and giving high-level commitment to working collaboratively.

Once the commitment had been made and the principles ironed out, implementing cervical screening in sexual health services provided a quick win for collaborative commissioning, with immediate benefits for the local population.

Although the contract value of cervical screening is relatively small, setting up a formal contractual and financial relationship with NHS England has provided clarity that women receiving cervical screening in sexual health services are participating in the national screening programme. This ensures the appropriate data are reported to NHS England, whereas before, reporting was haphazard.

The council and NHS commissioners acknowledged there was a problem and recognised that they needed to find a solution together. NHS England provided valuable data. It took time and hard work on all sides but the relationship was open, honest and constructive, and the process was driven by the needs of the population.



**“Initially it was just very slow and a bit in everyone’s ‘too hard to do’ box until the collaborative commissioning forum came together and cervical screening was identified as a quick win.”**

**Helen Dickinson**

Public Health Programme Manager, NHS England Cheshire and NHS Improvement North West

### **Lessons learned**

Transformation requires dedicated resources. With each council commissioner responsible for several topic areas in addition to sexual health, they had very limited capacity to take on more tasks. The part-time pilot programme lead appointed by CHAMPS to support the sexual health commissioning pilot, with funding from each public health director’s budget, provided local advocacy, facilitated the process, ensured everyone was included in discussions and followed through to make sure action was taken.

Public health leadership is key to success. The Cheshire and Merseyside public health directors and the NHS England regional head of public health championed the search for a collaborative solution, and this was influential in ensuring that all commissioners came on board.

Joining up commissioning does not have to be complicated or controversial. Although much work went into its development, the cervical screening solution implemented in Cheshire and Merseyside was pragmatic and relatively straightforward once knowledge and expertise had been pooled to work it out.

A focus on the needs of the local population facilitates agreement on shared goals. Screening data and insight research confirmed that cervical screening in sexual health services was needed, paving the way for agreement between council and NHS England commissioners on objectives and the collaboration required to achieve them.

A contractual relationship brings benefits for commissioners and providers. The NHS England contract gives providers security in knowing the volume of activity expected of them and the financial reward attached, while for commissioners it allows performance monitoring and data collection.

The contracting model adopted for cervical screening can be used for other NHS England-commissioned services to be delivered by sexual health providers. In Cheshire and Merseyside, a similar approach is now being taken to the introduction of HPV vaccination for men who have sex with men.

**“It was getting the public health directors on board that was really key. If we hadn’t had them on board from the start, we wouldn’t have got much further.”**

**Helen Dickinson**

Public Health Programme Manager, Cervical Screening Commissioning Team, NHS England Cheshire and Merseyside

**“NHS England were brave and decided to put their money where their mouth is. They said they would pay up to a set number of screens in each local authority area, and we could then build that into our service specification and contracts.”**

**Simon Bell**

Public Health Commissioning Manager and Programme Lead for Sexual Health, Halton Borough Council

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# Integrated sexual health commissioning across Leicester, Leicestershire and Rutland

Joint commissioning of a specialist sexual health service, and use of Section 75 agreements to align IUS fitting for contraceptive and non-contraceptive purposes

“Coming to the table with a very open, clear approach recognising what the differences may be across the landscape – that worked quite well.”

**Ivan Browne**

Director of Public Health, Leicester City Council

“The Section 75 was a nice coming together of the need of the local authority to balance its books with the public health duty of the local authority and the NHS to improve the health of the population, regardless of who pays.”

**Mike Sandys**

Director of Public Health, Leicestershire and Rutland county councils

## Keys to success

- Successful collaborative commissioning depends on strong relationships, a clear shared vision, equal respect for each partner’s priorities and a willingness to compromise.
- Delegating the NHS’s commissioning responsibility for intra-uterine system (IUS) fitting to local government is a cost-effective way to avoid service gaps arising from the fragmented commissioning of this service for contraceptive and non-contraceptive purposes.
- Adding an extra schedule to existing Section 75 agreements is a relatively simple mechanism for delegating the commissioning of specific services.

## Outline

Leicester, Leicestershire and Rutland (LLR) have identified a way to work collectively on sexual health that respects their diverse organisational, political and geographical characteristics. This has been supported through the development of strong relationships, in particular between the public health teams which manage sexual health commissioning. There have been two major outcomes of this collaborative approach.

Firstly, the three councils jointly procured the LLR Integrated Sexual Health Service (ISHS) in 2013 and 2018. This open-access service allows residents to choose where to attend across the three areas, without the need for cross-charging between councils. The 2018 procurement included the Haymarket accommodation project which resulted in a new service hub in a central Leicester shopping centre, offering a more attractive and accessible location for residents and an innovative service model, while reducing rental costs.

Secondly, a Section 75 agreement was used to enable each council to commission IUS fitting for non-contraceptive purposes, including for heavy menstrual bleeding, as per National Institute for Health and Care Excellence (NICE) guidance, on behalf of their local CCGs. This took the form of a new schedule added to existing Section 75 agreements. In this way, the same general practice and specialist sexual health providers are now able to fit IUSs for both contraceptive and non-contraceptive purposes, costs are allocated to the appropriate commissioner, and local women can access a seamless service.

## Context

The city of Leicester is a compact urban area, with a predominantly young and ethnically diverse population of around 350,000, including 37 per cent self-defining as Asian/British Asian, and with high levels of deprivation. By contrast, the county of Leicestershire has a mix of small towns and rural areas, with around 690,000 residents, and Rutland is similarly rural, with around 39,000 residents. Both counties have ageing, predominantly white populations and lower levels of deprivation than the city.

Leicester, with its younger and more deprived population, bears the greater burden of sexual health inequalities. Teenage conception rates are declining across the three council areas, but the city's rate of 23.5 per 1,000 remains above the England average of 17.8, while Leicestershire's and Rutland's are low, at 12.3 and 6.1 respectively.

Conversely, the prescribing rate of long-acting reversible contraception (LARC) is lower in Leicester, at 25.8 per 1,000 (excluding injectables), whereas Leicestershire's and Rutland's rates are closer to the national average of 47.4, at 44.9 and 47.8 respectively. New diagnoses of STIs across the combined area are relatively low and, of the three, only Leicester has high prevalence (according to NICE's definition) of diagnosed HIV, at 3.93 per 1,000 population in 2017. However, rates of late HIV diagnosis are above the England average; syphilis and gonorrhoea rates are showing the national trend which is creeping up; and chlamydia detection rates in 15 to 24-year-olds were below the Public Health England recommended level of 2,300/100,000 (at 1,934 in Leicester, 1,703 in Leicestershire and 2,238 in Rutland) in 2018, although higher than in 2017.

Leicester City Council is a unitary authority governed by an elected mayor, who appoints and chairs a small executive team. Leicestershire (upper tier) and Rutland (unitary) county councils have a cabinet-led structure. Leicester City CCG is co-terminous with the city council, while West Leicestershire CCG and East Leicestershire and Rutland CCG both serve Leicestershire, and the latter also serves Rutland. Leicestershire and Rutland councils share a public health director and the services of a public health team employed by Leicestershire County Council, while Leicester has its own. A sustainability and transformation partnership (STP) operates across the three areas.

### Approach

Leicester, Leicestershire's and Rutland's councils have worked together and across the system to collectively commission sexual health services for the greatest benefit of their residents. This is supported by a legal and formal partnership agreement and subsequent integrated sexual health partnership board, chaired by the directors of public health.

The different councils have slightly different strategic approaches and governance structures. For example Leicestershire and Rutland councils have sexual health strategies, with specific subgroups including a commissioners' group (of which Leicester City Council, NHS England and the three local CCGs are members). This aims to align sexual health commissioning intentions and pathways across the area, utilising individual organisational governance structures as needed. Leicester City Council does not have a sexual health strategy but has a specific health needs assessment, with actions for local commissioners that form its action plan. Strategic priorities on sexual health remain aligned across the three council areas, with changes in emphasis based upon local population need. Although the approaches and governance structures are different, strong relationships, and the desire to work in partnership and avoid duplication, have created opportunities to work collaboratively across the system to improve clinical and efficiency outcomes.

This case study provides two key examples of this integrated working approach:

- joint commissioning of a Leicester, Leicestershire and Rutland specialist sexual health service
- use of Section 75 agreements to reconnect elements of sexual health commissioning (aligning IUS fitting for contraceptive and non-contraceptive purposes).

Collaborative commissioning, in particular the use of Section 75 agreements, has benefited from the existing relationships between individual councils and their local CCGs. For example, in Leicestershire, where public health is a standalone department in the council, the director of health and integration within the chief executive's department leads on Section 75 development for health and social care and is well-connected with key officers in the CCGs.

Because aspects of sexual health are just a small part of several different CCG officers' roles, it has not always been easy for them to be actively engaged in sexual health. However, the working relationships have been strengthened through the involvement of the two county CCGs in the development of the Leicestershire and Rutland sexual health strategies, and the engagement of all three in agreeing new commissioning arrangements for IUS fitting.

The Leicestershire and Rutland director of public health sees his own role as fostering a culture of joint working, agreeing common approaches with peers in Leicester City Council, communicating the positive impact of partnerships, and advising, supporting and troubleshooting when needed. Schemes such as acquiring the new city centre premises required more leading from the front and 'holding the line' for his own council, in terms of balancing costs and savings, while he describes his approach in relation to the Section 75 negotiations as 'backseat' system leadership, and acknowledges the skills of his public health commissioning team in achieving successful outcomes.

The Leicester City Council director of public health stresses the importance of buy-in from councillors and their ability to act as a voice for the public, highlighting the role of scrutiny, the health and wellbeing board and lead members. Because of the mayoral structure of the council, the lead member for health plays a prominent role – taking a close interest in the development of sexual health commissioning, especially for the city's own population. However, while the lead member's role as a champion can be invaluable on more sensitive areas of work, there has been less need for their involvement in the development of the Section 75 arrangements, which are more pragmatic than political.

## Example 1: jointly commissioned specialist sexual health service

### Objective

The overarching collaborative commissioning objective was:

- to commission a single integrated sexual health service with open access, for the populations of Leicester, Leicestershire and Rutland, within the context of a reducing budget.

In 2013, the three councils jointly procured a single integrated sexual health service. In 2018, following a service review, refreshed needs assessment and extensive public consultation, a joint re-commissioning exercise was undertaken using a competitive tender process, and the same provider was successful in winning the new contract. The integrated service can be used by residents of all three local authority areas at any site, on an open-access basis. The contract is activity-based, with the council of residence being charged for each attender using an integrated sexual health tariff, so there is no 'out of area' cross-charging between the three. Each council has a separate contract with the same provider, and these mirror each other except for services to meet specific local needs and overall contract value (such as an emphasis on black, Asian and minority ethnic communities in Leicester).

An accessible, central Leicester shopping centre building has been leased and refurbished by the city council to fit the new service model, which uses self-service technologies such as vending machines and booking-in kiosks. Being based outside the NHS gave the commissioners the freedom to move the service from its previous, less accessible, higher-rent NHS premises.

The council rents the premises and sublets it to the provider as a condition within the service specification, and through the lower rental charge, along with innovation fostered by a dedicated fund within the commissioned budget, has managed to maintain the clinical service activity. The new site has seen an increase in patient volume in its first few months.

Collaborative commissioning is led through the Integrated Sexual Health Service partnership board. There was joint project management of the procurement. The Leicestershire/Rutland public health team led on the overall project management of service re-commissioning as well as the service modelling, quality and performance, and mobilisation workstreams; while the Leicester public health team led on the consultation and engagement, procurement and accommodation workstreams. The two public health teams jointly manage the contract via a single contract management process.

While NHS commissioners are not parties to the integrated sexual health service contract, the service specification requires the provider to work with NHS England to deliver opportunistic cervical screening. This was agreed at the joint sexual health commissioners' group, following which NHS England established its own contracts with the sexual health provider for this service. Collaborative commissioning of HIV treatment and care with sexual health services has been considered but judged impracticable because of the requirement for inpatient care, the larger geographical footprint and the non-competitive, provider-based approach of NHS England's HIV specialised commissioning.

## Example 2: use of Section 75 agreements to reconnect elements of sexual health commissioning (aligning IUS fitting for contraceptive and non-contraceptive purposes)

### Objective

The objective of using Section 75 agreements between councils and CCGs was:

- to enable the same providers commissioned to fit IUSs for contraceptive purposes to fit them also for non-contraceptive purposes.

**“It made sense to use the same workforce, with the same training and quality requirements, to deliver a non-contraceptive IUS fit on behalf of the CCGs.”**

### Janet Hutchins

Public Health Strategic Commissioner,  
Leicestershire County Council

A gap in service provision arose because the Health and Social Care Act 2012 gave commissioning responsibility to councils for contraception and to CCGs for gynaecology, including treatment of heavy menstrual bleeding (HMB). GPs and sexual health services had traditionally provided IUS fitting both as a form of LARC and as the first-line treatment for HMB recommended by NICE, but this service now needed to be separately commissioned depending on its purpose.

Leicester, Leicestershire and Rutland councils commissioned IUS fitting from the specialist sexual health service and also from general practice, as part of a suite of community-based services contracts.

These new contracts covered IUS fitting for contraceptive purposes only, but faced with a vast range of large, complex services to commission, CCGs could not immediately prioritise the commissioning of IUS fitting for HMB. According to the Leicester sexual health commissioning lead, women needing an IUS for HMB were being ‘bounced around the system’ – from GP to sexual health services, and from specialist gynaecology back to the GP, because none were now commissioned to provide this service. In other cases, the GP might agree to fit an IUS for HMB using the council-commissioned budget but, because this was outside the scope of the contract, there would be no governance or authority to cover it – and it placed a drain on funds intended for other purposes.

Opportunities to resolve the problem arose through local health and care integration work supported by the Better Care Fund in Leicestershire and Rutland, and in Leicester by other arrangements for joint commissioning; in both cases by ‘piggy-backing’ onto the large Section 75 agreements set up by the CCGs and councils to delegate certain commissioning responsibilities from the NHS to local government and vice versa. This was a pragmatic solution that avoided the need to develop a specific Section 75 agreement for IUS fitting.

Separate negotiations were initiated between the sexual health commissioners in each council and their individual CCG(s) (two in Leicestershire and one each in Rutland and Leicester), and the approval processes required by each were followed. In Leicestershire and Rutland, the councils and CCGs appended a schedule on IUS fitting to their existing Section 75 agreements, while in Leicester, a schedule on IUS fitting became one among many within a new Section 75 agreement for social care that was being developed. The latter took some time because of delays in negotiating the main body of the agreement, but putting in the schedule was fairly straightforward.

As part of the required processes leading up to approval, a joint consultation with the public and stakeholders, including GPs and sexual health service providers, was completed. The draft Section 75 schedule was also shared with the relevant CCG committees for input. The support and engagement of the county council cabinets and CCGs had been gained in earlier discussions regarding their linked sexual health strategies. In Leicester, the commissioner also worked with a GUM trainee to look at the service pathway, and sought agreement through the Leicester City Council/CCG joint commissioning board. The lead member for public health played a key role in the city council's approval process.

To streamline the approach across the three councils, the sexual health commissioners jointly drafted the Section 75 schedule, as well as service specifications on IUS fitting for HMB, to be included in their contracts with the sexual health service provider and GPs. Clearly defining the scope of the service was important – namely just the fitting of IUSs, for which no additional training or qualification was required for clinicians. Any associated or follow-up care would be commissioned by the CCGs directly from GPs or specialist gynaecology services.

Local residents can now use the integrated sexual health service at whichever site they prefer if they need an IUS fitting for HMB but, unlike the rest of the sexual health service, a GP referral is required. The provider invoices the service user's council of residence, which then recharges the relevant CCG. In addition, GPs who are commissioned by the councils to fit IUSs for contraceptive purposes are now also commissioned to fit them for HMB. Where an IUS is fitted for both contraceptive and non-contraceptive purposes, the cost is shared 50:50 between the council and CCG. Financial monitoring is done through the general monitoring of the Section 75 agreement. The commissioners are now looking at data returns and are considering developing a new clinical template for primary care, to make it easier for practices to report on the reason for IUS fitting.

**“There was a strategic need to draw things together and we came to the pragmatic decision that, rather than having a separate Section 75 for sexual health work, we could reduce the bureaucracy by piggy-backing onto what was already there.”**

**Mike Sandys**

Director of Public Health, Leicestershire and Rutland county councils

**Challenges**

While the integrated sexual and reproductive health service has a footprint across the three council areas, there was a separate contract between the provider and each council. Similarly, each council required a separate Section 75 agreement with the relevant CCG(s), and each one necessitated different legal advice. Each council and CCG had their own distinctive approvals process, including consultation, scrutiny, the health and wellbeing board and sign-off by the cabinet or the mayor's executive team. The commissioners worked closely together to share workload and standardise documents but had to allow time for each organisation to follow its due process, as well as for delays dependent on the main Section 75 development process.

The differing approval processes of each council were even more challenging when steering through the joint sexual health service procurement, as decision-making schedules were staggered, and a later decision by one council could necessitate revisiting an approval already granted by another. The commissioners maintained timely and open communication to anticipate and respond to this and ensured good project management was in place, with the support of Leicestershire's corporate transformation unit. Public health directors would intervene to resolve issues within individual councils if necessary.



There was a tension between the desire of each council to prioritise their specific requirements, whether the needs of their local community or their established internal procedures, and the need for compromise in order to achieve successful collaboration. A pragmatic, staged approach to negotiation was found to be useful, securing agreement to different elements in turn rather than aiming for 'all or nothing'. In the main, a recognition of the financial risks of not collaborating, alongside the public health benefits, ensured the adoption of common approaches despite different organisational cultures.

Leicestershire and Rutland have their own similar but respective sexual health strategies, whereas in Leicester, because of the range of other pressing health needs and inequalities among its population, engaging in sexual health strategy development was not deemed a priority. However, this did not prevent the city and county sexual health commissioners from successfully aligning the commissioning approach across all three councils and involving all the CCGs.

### **Achievements**

The use of Section 75 agreements to commission IUS fitting for non-contraceptive purposes has enabled women across Leicester, Leicestershire and Rutland to access the appropriate first-line care for HMB, at a site of their choice, without obstacles. They are no longer being 'bounced around the system'.

The qualifications and skills of clinicians who fit IUSs are now being used more cost-effectively through two commissioned services rather than one and, because of their larger IUS-fitting caseload, it is easier for them to meet the minimum practice requirements for maintaining their qualifications and improve quality.

On sexual health, despite the challenges along the way and the differences in organisational structure and process, the three councils have managed to build a strong commissioning partnership. The strength of the partnership and the sharing of mutual public health goals formed the basis for successfully negotiating the Section 75 arrangements for IUS fitting. Other benefits of the partnership have included a larger contract value for the integrated service attracting more potential providers, the procurement of a high-quality sexual health service across a geographical footprint matching the mobility of the local population, the sharing of savings from innovation and relocation, the elimination of bureaucratic cross-charging between the three councils, and a streamlining of contract management and data reporting processes for the provider.

The collaboration between the three councils on sexual health provides a tangible example of successful collective working for the newly-developing STP, as it looks at how joint commissioning could be done across the same footprint on other health issues.

**“The relationship, particularly at public health team level, has been really important, because although there are variations that might shift the priorities in each area a little bit, so many of the issues are common – and we see the value of a collaborative approach and trying to work in the same way to achieve the same kinds of services for our populations.”**

### **Janet Hutchins**

Public Health Strategic Commissioner,  
Leicestershire County Council

## Lessons learned

Commissioning IUS fitting for contraceptive and non-contraceptive purposes from the same providers makes the best use of available resources. In Leicester, Leicestershire and Rutland, IUS fitting for HMB is integrated into existing sexual health and primary care contracts, with clinicians using the same training and qualifications for both.

'Piggybacking' on existing Section 75 agreements to delegate specific CCG commissioning responsibilities to the council can overcome potential gaps in service provision. Here, putting in place a dedicated contract purely for IUS fitting for HMB would have been a challenge for hard-pressed CCGs, but delegating the responsibility to councils already commissioning the same service for contraceptive purposes was a relatively simple way to ensure provision was maintained.

When managing joint commissioning, it is important to build in sufficient time to ensure all partners' needs are addressed and their different approval processes are followed. The joint nature of the integrated sexual health service commissioning in this area meant that key decisions made by one council could have knock-on implications for the decisions made by others, and this required time, careful management and good communication between commissioning teams to work through.

In order to commission collaboratively, it is important to build strong relationships and have a clear shared vision from the outset. The commissioners in Leicester, Leicestershire and Rutland, and their public health directors, had a long history of working together, undertook needs assessments and ensured that commissioning objectives were aligned, enabling them to support each other and weather the storm when obstacles arose.

**“The health needs assessment is the backbone to all the work we do. Looking at the needs of the population is a public health role, as part of our commissioning role.”**

### **Liz Rodrigo**

Public Health Lead Commissioner,  
Leicester City Council

**“Looking at the challenges around STPs at the moment, it's really great to have a tangible demonstration of what you can do collaboratively between all those organisations.”**

### **Ivan Browne**

Director of Public Health, Leicester  
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# Transforming sexual health services in Plymouth

## Collaborative commissioning using a negotiated procedure

“Contracting and procurement are important, but what’s most important is that our population and patients get the right care they need without having to negotiate through barriers.”

**Dr Ruth Harrell**

Director of Public Health, Plymouth City Council

“Being told we were the preferred provider through a fair process...at least it gave us a breathing space and the confidence that they had some faith in us, they wanted us to do well.”

**Dr Zoe Warwick**

Consultant in Sexual Health and HIV, University Hospitals Plymouth NHS Trust

### Keys to success

- Using a negotiated procedure for commissioning encourages open communication between the organisations involved, in turn fostering relationships of trust and shared system leadership.
- A balance is needed between contract management and helping to shape the system. With a decreasing budget and rising demand, transparency, flexibility and a collaborative approach to finding solutions are essential.
- Commissioning expertise within the local authority can support public health specialists in finding appropriate commissioning mechanisms to meet their objectives.

### Outline

Plymouth City Council re-commissioned sexual health services in 2017. It used a negotiated procedure, in accordance with Public Contract Regulations 2015, to collaborate with existing providers of local sexual health services to design a new integrated model of provision. The approach was supported by the city’s shared strategic vision and integrated commissioning function, whereby council and CCG budgets had been pooled as a response to increasing financial pressures and the risk of system fragmentation.

Public and system engagement were key drivers of the re-commissioning. This included system design sessions to better appreciate people's experience of using services, and an extensive online consultation to understand what people wanted from future services.

While formal procurement processes were followed, a series of negotiation meetings were used to agree the detail of the specification and the contractual arrangements. This approach facilitated a relational, rather than transactional, approach to commissioning and service redesign.

## Context

Plymouth is the 15th largest city in England, with a growing population currently numbering 263,070. Due to a large number of students, the percentage of 18 to 24-year-olds is high (12.2 per cent compared to 8.8 per cent across England). The population is becoming more ethnically diverse but is still largely white British (93 per cent at the 2011 census). Deprivation levels are above the England average and rising, with one small area among the most deprived one per cent in England. Life expectancy is slightly below the England average and there are significant health inequalities.

In 2018, Plymouth had the 34th highest rate of new STI diagnoses out of 326 council areas in England (1,010 per 100,000 residents, compared to 784 in England). Overall, 2,656 new STIs were diagnosed. The rate of gonorrhoea has more than trebled since 2012. With 24 per cent of the 15 to 24-year-old population screened, the chlamydia detection rate was 2,350 per 100,000 (above the level of 2,300 that Public Health England recommends councils should be working towards).

HIV prevalence in Plymouth is relatively low (1.45 diagnosed per 1,000 aged 15-59, compared to 2.32 across England), with a late diagnosis rate of 39.5 per cent (compared to 41.1 per cent across England).

Teenage conceptions in Plymouth have fallen significantly, from a rate of 54.7 per 1,000 under-18s in 1998 to 25.1 in 2017, reflecting a structured and consistent focus on this issue over the last decade. Recent capacity-building for long-acting reversible contraception (LARC) in specialist services and general practice has resulted in a total prescribed LARC rate (excluding injectables) of 64.2 per 1,000 women aged 15-44 years in 2017, compared to 47.4 in England.

In 2015, Plymouth City Council and NHS Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) signed a Section 75 agreement to merge the public health grant, the CCG spend in the Plymouth area and the council's budget for adult social care, education and skills and wellbeing. This arose out of a process of strategic leadership development initiated by the health and wellbeing board and the council's chief executive, following the move of public health into the council in 2013.

One shared plan now provides the strategic vision of all partners in the city, including a sub-plan for health and wellbeing, driving a collective approach to improving outcomes and reducing health inequalities. There is an integrated commissioning function to meet the challenges of increasing need for health and social care services and escalating financial pressures. The council's public health team is part of the office of the public health director, and sits alongside the local authority commissioning team and CCG colleagues. Leadership on integrated commissioning is provided by a director of integrated commissioning, and there is an integrated commissioning board.

# Transforming sexual health services through collaborative commissioning

## Objectives

The objectives of the sexual health service transformation were:

- to develop an integrated model of service provision, where people could get all their sexual and reproductive health needs met in one place
- to increase the focus on prevention, alongside clinical service provision
- to make financial efficiencies, in order to cope with the year-on-year cut in the public health grant.

## Approach

The council started re-commissioning its sexual health services after a detailed needs assessment. Public and system engagement were key drivers of the process. This included system design sessions to better appreciate people's experience of using services, along with an extensive online consultation to understand what people wanted from future services. Nearly 700 responses were analysed and used to inform the new service specification.

At the time, there were four distinct sexual health services which generally worked well together but, for example, a woman wanting to get tested for STIs and to have a contraceptive implant fitted would have to go to two separate services in different places. Achieving a more integrated experience for service users was therefore a primary driver for service transformation, along with a desire to give greater priority to prevention and ultimately reduce the demand for clinical services. A further driver was the need for significant cost efficiencies, which made the continuation of four separate services unsustainable.

Having heard reports of commissioning processes elsewhere causing destabilisation, system fragmentation or unnecessary costs without evidence of improved quality or outcomes for the local population, the team spent a long time considering the best way forward. It sought extensive advice from the council's internal legal and procurement experts, as well as external legal advice. This resulted in a decision to use a negotiated procedure to commission the new service in accordance with Public Contract Regulations 2015. The procedure was discussed and agreed in commissioning team meetings and referred to the commissioning board for approval.

Re-commissioning was led by an experienced and well-respected specialist in public health with a good understanding of sexual health, supported by strategic commissioning colleagues. In line with procurement advice to test the market, a prior information notice (PIN) was issued calling for expressions of interest from any providers who felt they had the right skills and expertise, and could secure the right premises and facilities, to deliver the integrated service model required. A number of responses were received, but the only submission that met the commissioners' criteria was from the current providers, responding as a collaborative.

The collaborative consisted of the hospital-based GUM service, a community interest company providing community contraceptive services, and two voluntary sector organisations – one specialising in HIV and the other providing services for young people. Anticipating the council's decision to re-commission, the GUM provider had already started to prepare by ensuring its service was as lean as possible, undertaking workforce remodelling to reduce costs, and making successful approaches to NHS England and the CCG to secure funding for aspects of its service not covered by the council's public health grant (namely cervical cytology, vulval dermatology, pelvic pain and sexual dysfunction).

In addition, it had brought together the main local provider organisations and agreed to work together to submit a collaborative bid. While all had supported this idea in principle, further discussions were necessary to understand what this would mean for all providers.

The council was able to conclude that these were the only providers who had demonstrated they could provide the proposed integrated service, and that it would therefore undertake a negotiated procedure with them to commission the new service. From that moment on, the usual tendering process was applied but with just the one bidder. An invitation to tender was issued and evaluation processes included an evaluation board, a scored framework, advice from a clinical expert and a presentation to an evaluation panel. The bidders also faced questions from a young people's panel, recruited with support from colleagues in the council working with children and young people.

After successfully completing these stages, the providers submitted a best and final offer. This was followed by business negotiation meetings and, once all details were agreed, the council's cabinet approved the contract. The public health portfolio holder and shadow portfolio holder had been regularly briefed during the whole re-commissioning process.

The contract was signed between the council and the NHS hospital trust, as lead provider, which in turn signed subcontracts with the other three providers. However, in practice the contract is a shared document and all the providers are equally signed up to its objectives as partners.

The providers were advised that financial efficiencies of 11 per cent would be needed over the three-year contract term, after which the need for more efficiencies could not be ruled out. They were asked to share responsibility for achieving the best outcomes within this financial envelope. The contract was awarded with the option to extend by three separate years.

It included a one-off £120,000 development grant to cover costs associated with service transformation, on the basis that 'the system needs to pay' rather than 'the provider must absorb the costs'. At a recent contract review, the lead provider requested a three-year extension in order to provide the security needed for them to invest in a new patient records system with greater functionality. The commissioners felt this was reasonable and agreed the extension. This is an example of the iterative negotiated approach pioneered in the council, as opposed to a traditional contract management model.

All parts of the system are represented on a mobilisation and a governance group, and contract monitoring meetings are held between the council and the lead provider. All partners are now considering how to rationalise these meetings and create a new whole-system forum to discuss current challenges and agree jointly where efforts should best be focused.

Launched in October 2017 and branded 'Sexual Health in Plymouth' (SHiP), the new service is characterised by the following:

- a clear focus on prevention and self-management through a systematic approach to communication of information and advice, including innovative uses of media and marketing techniques to support behaviour change
- improved accessibility by ensuring that services are delivered in the most appropriate settings and at the most convenient times for the population, with specific focus on high-risk and vulnerable groups
- an integrated 'front door' with a central telephone number and online system for advice, information and self-management
- a clear focus on optimisation of new technologies and treatments, including online services
- a focus on cost-effectiveness, with all partners sharing responsibility for delivering services within defined budgets.

Implementation has entailed some major structural changes. The NHS hospital trust and the community interest company worked together on the 'nuts and bolts' required to run an integrated service, including merging their patient record systems. Then the sexual health teams of those two organisations were merged, with the community interest company staff transferred into the trust. A review of premises is to follow. An online STI testing service (mainly targeting asymptomatic over-16s) has been up-and-running since September 2018, its development informed by an evidence review on how e-health services can improve access for certain groups, a qualitative study of views about online STI testing, and focus groups with young adults on its design and functionality.

The introduction of the new model has been incremental. The process of integration is constantly underway, with providers regularly reviewing capacity and where it could be re-allocated across the system to best effect.

The approach is fluid and responsive, rather than sticking to a delivery model tightly defined in the contract's service specification. For example, to meet the needs of homeless people and street sex workers, a new service was initiated out of a homeless hostel and day centre. However, after a few months of operation attendance rates remained low, so the service was stopped and the capacity moved elsewhere.

The integrated contract does not include abortion services, commissioned by the CCG, or HIV treatment care, commissioned by NHS England. However, links with CCG commissioners are close because of the integrated commissioning system, while HIV specialised commissioners, though based over two hours away in Bristol, have remained engaged and provided input to sexual health commissioning when needed. Services for HIV, abortion and sexual health are situated next to each other in the hospital trust, with an integrated clinical team ensuring seamless pathways for service users.

Sexual health was the first service to be contracted in Plymouth in the way described above. Since then a similar approach has been taken to the commissioning of other services for the city, such as an integrated contract for children's services, with a single provider delivering three council and CCG-funded functions for the same population group.

**“It was a question of saying ‘we want you to help us, to work with us to design the new service’. It’s still a formal and contractual arrangement but it’s not a commissioner wagging a finger. It’s about saying ‘these are our challenges, this is our model, this is our budget, how are we going to do this?’”**

**Laura Juett**

Public Health Specialist, Plymouth City Council

### **Challenges**

The council faced uncertainty as to how innovative its commissioning could be whilst working within a legally governed framework. Aware that local conditions in the South West can make it difficult for new providers to come into the market, it also recognised the strength of the existing providers, who understood local needs and were willing to work together. It could see the advantages of being able to work with them directly but a competitive element was required in the early stages, followed by a tendering process involving intensive effort and lengthy time away from clinical services for senior clinicians. By using the negotiated procedure, however, the council was able to ensure that the chosen providers could focus their efforts on how to meet the service specification without the pressure of a competitive process. While judging that the time and effort expended on the tendering process could have been better directed elsewhere, the clinician leading the bid

acknowledges that it provided a lever to make long-needed changes and transform the service at a pace that would otherwise not have been possible.

Similarly, service transformation has placed enormous pressure on clinicians and other staff who have had to carry on running extremely busy services at the same time. The lead commissioner recognises that this has, at times, placed a drain on goodwill and staff morale. In retrospect, the creation of a dedicated post (resources permitting) to support the transformation process could have helped relieve some of these pressures.

Declining budgets, coupled with rising demand, present a major and ongoing challenge. Because of cuts to public health funding, the council has had to include yearly budget reductions in the sexual health contract. However, the number of people using the service is growing, STI rates remain high, and the new online service has not yet led to a reduction in demand for face-to-face services. While the block contract (as opposed to an activity-based tariff) provides a necessary means to control costs, it has introduced risk into the system.

Maintaining a collaborative relationship between all providers in this context is challenging but essential. Rather than using traditional performance management approaches, the council has sought to help with demand management by providing upfront funding for new service developments and working with the providers to identify ways forward. Nevertheless, how the city continues to fund its growing population's needs will be a constant challenge over the next few years.

There have been significant workforce challenges. A number of staff within the provider organisations have retired or left, some because they preferred not to become part of the new integrated service. Valuable skills and knowledge have been lost, recruitment has been a struggle, and difficulties will continue in the medium term until new staff are recruited and trained up. However, in the longer term this should

facilitate the creation of a more integrated dual-trained workforce.

Bringing together providers highlighted differences in organisational structure, practices and culture which can pose a challenge to integration. By using a relational approach the council has provided leadership to support culture change and help resolve differences. This change is ongoing and can still be hard, but there is a strong commitment from commissioners and providers to working together with transparency, allowing concerns to be expressed and supporting each other through difficult decisions. In this way, problems – and how to resolve them – are owned by the whole system.

**“I don't feel we were let off lightly but I do think it's much better to only put one service through all of that [procurement process], because it was a massive amount of work.”**

**Dr Zoe Warwick**

Consultant in Sexual Health and HIV,  
University Hospitals Plymouth NHS Trust

### **Achievements**

The city's integrated commissioning function has facilitated a collaborative approach to the commissioning of sexual health services. There is a shared understanding of the whole system and a recognition that the budget is allocated to meet the needs of the population, regardless of who holds which funds. The focus has been on creating an inclusive culture and getting everyone involved in thinking how things could be done differently.

Partners recognise the importance of relationships and learning as drivers for change and improvement. Although conventional contract management processes are in place, there is an acceptance that service transformation may not follow defined plans and that the system can adapt as necessary. This in turn means that SHiP is more agile and equipped to deal with the



changing needs of the local population. For example, providers have collaboratively taken the initiative to move funds between their respective services, increasing the budget for prevention.

A large wellbeing system design group, with membership including the voluntary sector, statutory providers, the council, the CCG, GPs, pharmacies, Healthwatch and local councillors, supports the development and implementation of the city's health and wellbeing strategy. This group served as a forum for widespread engagement in sexual health system redesign, including through discussion at its meetings and a dedicated engagement event where case studies about people in Plymouth were presented to stimulate creative thinking about how the system should respond to their sexual health needs.

While the STP does not have a specific workstream on sexual health, its prioritisation of prevention supports the drive for a greater focus on prevention in sexual health.

Sexual health services in Plymouth are now more accessible. It is too soon to judge any impact of the changes on public health outcome indicators. However, the key success, says the public health specialist who led the commissioning process, is having created a completely different culture across the sexual health system.

**“I’m proud of our collaborative approaches. We’ve taken a long time to understand each other’s positions and points of view, and hopefully that means we’ve got a better understanding of what people need and want.”**

**Laura Juett**  
Public Health Specialist, Plymouth  
City Council

## **Lessons learned**

Commissioning is about collaboration and co-production, not just contracting. In Plymouth, system leadership involved giving up perceived hierarchies and creating the space for all parties to come together as equals so that the issues, challenges and opportunities could be explored and people could have shared ownership. It is important to invest time in those processes.

An experienced and respected public health specialist can be a good system leader. In Plymouth, the director of public health provided support by checking that things were going in the right direction, troubleshooting when needed and making sure that senior colleagues and councillors were appropriately briefed, while the public health specialist mainly focused her energies on working with providers and ensuring appropriate process was followed.

It is not necessary for public health staff to have technical expertise in procurement if this can be accessed within the council. The specialist based in the public health directorate worked closely with procurement, legal, finance and strategic commissioning colleagues based in the people directorate, including the holder of a joint post with the CCG, who all contributed expertise and helped to find solutions.

The location of commissioning in local government facilitates the prioritisation of prevention. In Plymouth, this meant the council supporting the sexual health provider collaborative's decision to maintain funding levels for voluntary sector partners. The public health director sees it as her role to keep a focus on prevention in the STP and ensure that the role played by the voluntary sector is not underestimated. Innovative ways of measuring the impact of prevention services are needed in order to better demonstrate the ongoing value of this investment.

**“When you are struggling financially you can go one of two ways – either fight over every penny and get an adversarial relationship with your providers, or you say ‘let’s work together and do the best’. We did the latter.”**

**Dr Ruth Harrell**

Director of Public Health, Plymouth  
City Council

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# Conclusion

The case studies described in this publication show how local authorities and their commissioning partners around the country are implementing the principles of Public Health England's 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV'. The issues addressed and the local solutions identified vary between case studies, but they all provide learning about the value of collaborative commissioning and how it can be done successfully.

The need for whole-system commissioning is greater than ever, and the key messages included in 'Making it work' are still highly pertinent. The case studies provide examples to illustrate all of these messages, some more fully than others. They are reproduced below as an aide-memoire to consolidate the learning shared through the case studies themselves.

## Key messages<sup>15</sup>

Put people at the centre of commissioning, and base decisions on assessed needs.

Take service user pathways as the starting point for commissioning, with the aim of ensuring people experience integrated, responsive services.

Review whether existing service provision and configuration best meet identified needs for the area.

Maximise opportunities to tackle the wider determinants of health.

Build on the director of public health's role to deliver system stability and integration across the sector.

Draw on the expertise of clinicians and service users, and the public's views, to inform commissioning.

Build trust across commissioning organisations by developing strong relationships and dialogue with counterparts to develop local solutions.

Collaborate – a larger commissioning footprint can make the best use of limited resources to improve outcomes.

Document the approach to collaborative working, with clearly defined individual and collective responsibilities.

Ensure commissioned services have the capacity to educate and train the current and future workforce.

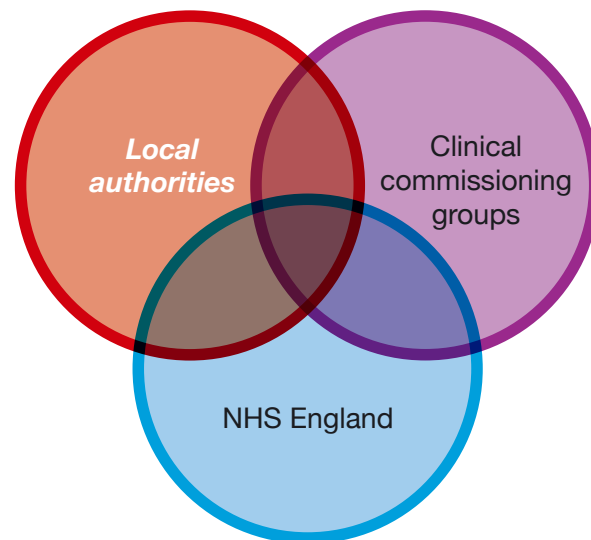
Acknowledge the economic climate requires new thinking and innovation – doing more or less of the same may not radically change outcomes or provide better value.

There is no one right way – it is for local teams to make collaborative commissioning for sexual health, reproductive health and HIV a local reality.

<sup>15</sup> From 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV' (page 6). Public Health England, 2014. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408357/Making\\_it\\_work\\_revised\\_March\\_2015.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)

# Appendix

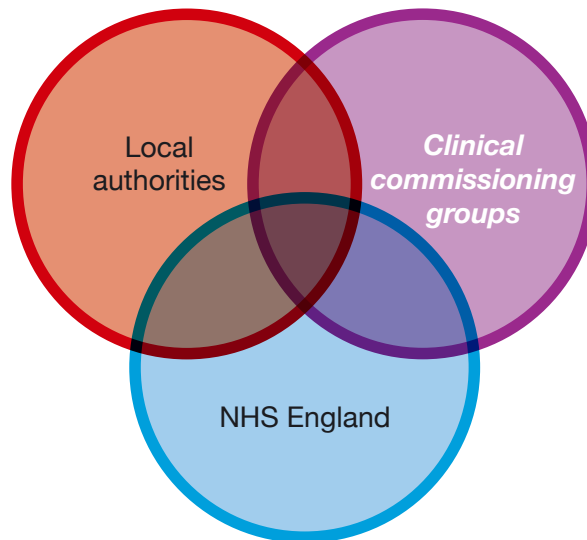
Figure 1. Commissioning arrangements from April 2013



## Local authorities commission

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

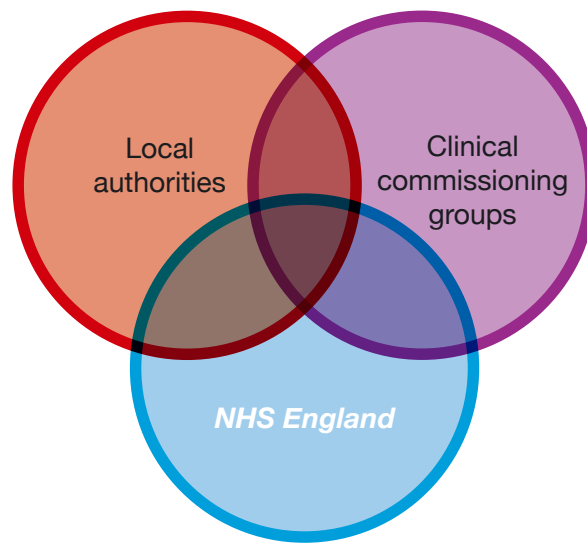
Figure 1. Commissioning arrangements from April 2013



#### Clinical commissioning groups commission

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

Figure 1. Commissioning arrangements from April 2013



### NHS England commissions

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

**From ‘Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV’ (page 6). Public Health England, 2014.**

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408357/Making\\_it\\_work\\_revised\\_March\\_2015.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)





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