



Work Stream 2 – tracer short report: Sexual Health Services (Understanding the new commissioning system in England: contexts, mechanisms and outcomes)

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Understanding the new commissioning system in England: contexts, mechanisms and outcomes

Work Stream 2 – tracer short report: *Sexual Health Services*

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter 'HSCA12'). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area ('tracers') in order to explore in more depth the issues arising in different contexts. This report summarises findings of our exploration of the commissioning of sexual health services. This 'tracer' was chosen because it sheds light upon the interaction between Clinical Commissioning Groups (CCGs) and local authority (LA) commissioners responsible for commissioning public health services.

Sexual health services encompass the provision of information and advice, prevention, support and treatment for a broad range of sexual health related issues, including: contraception, sexually transmitted infections (STIs; including HIV), termination of pregnancy, and sexual assault. These services are required by law to be offered on an 'open access' basis, i.e. to any member of the population of England wherever they choose, rather than restricted geographically to local residents upon proof of address.

National commissioning arrangements pre- and post-HSCA12

Prior to the HSCA12, sexual health services were commissioned by NHS Primary Care Trusts (PCTs), via 'enhanced service'¹ arrangements with general practices and community pharmacies and via services directly commissioned from a range of providers offering contraception and testing and treatment for sexually transmitted infections (Public Health England and Department of Health 2013). The HSCA12 divided and relocated responsibility for commissioning sexual health services to CCGs, NHS England (NHSE), and LAs, with the majority of services going to the latter as part of a more general shift of public health service responsibility in April 2013. Public Health England provides commissioning support at a regional level via its four regions and nine local centres. Table 1 below shows how sexual health commissioning responsibilities have changed as a result of the HSCA12.

¹ Locally Enhanced Services (LEs) and Direct Enhanced Services (DEs) were schemes commissioned by PCTs through various primary care contracts. LEs were locally specified and designed to reflect needs and priorities; DEs were nationally specified schemes that PCTs were required to establish.

Pre-HSCA12	Primary Care Trusts (PCTs) commissioned the majority of sexual health services		
Post-HSCA12	Local authorities commission...	Clinical Commissioning Groups commission...	NHS England commissions...
	Contraception over and above GP contract	Promotion of opportunistic testing and treatment	Contraception services commissioned through GP contract
	Testing and treatment of sexually transmitted infections (excluding HIV treatment)	Termination of pregnancy services (with consultation on longer-term arrangements)	Sexual assault referral centres
	Sexual health advice, prevention and promotion	Sterilisation and vasectomy services	HIV treatment

Table 1: The division of commissioning responsibilities for sexual health services pre and post Health and Social Care Act 2012

There is **no identifiable ‘programme theory’ (Weiss, 1998) for the specific shift of sexual health commissioning responsibility to LAs, but the explicit policy objective for the more general move of public health commissioning to local government was “[t]o realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing”** (Department of Health 2010, p.47). Connected to this objective was a suggestion that LAs responsible for public health, each led by a Director of Public Health overseeing a specialist team, would be more attuned to the needs of their local populations, more able to influence a broader range of factors affecting the health of those populations, and more democratically accountable (Department of Health 2012). The change was accompanied with a promise from government of a ‘ring fenced’ public health budget (Department of Health 2012).

In order to explore the impact of the HSCA12 upon sexual health services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers. This comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed Work Stream 2 interviews with 15 individuals from LAs, and sexual health service providers in two English Areas, which correspond to NHSE Area Team footprints (as originally conceived).² Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million, more than eight LAs, and a large city at its core
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million, more than five LAs, and a large central city.

In this short report, we first summarise the picture of sexual health services in Area 1 and Area 2 prior to the implementation of HSCA12. We then explore post-HSCA12 sexual health services commissioning within both Areas by considering three prominent themes: (1) Collaboration and boundaries of responsibility; (2) Fragmentation of treatment and prevention; (3) Democracy and politics.

² Area Teams were absorbed into the four existing regional teams when NHS England was reorganised in April 2015.

Pre-Health and Social Care Act 2012

In the early 2000s, commissioners and service providers in **Area 1** came together to form an Association in order to better deal with a range of problems including long waiting times, high 'did not attend' rates, and high STI prevalence. Regular meetings were established where issues could be discussed and lessons shared. Common service specifications were developed amongst the commissioners' sub-group and some Area-wide initiatives, such as a central access point for terminations of pregnancy, were instituted. Those involved credit the Association with facilitating significant improvements in service quality, as well as supporting high quality training, across Area 1. Prior to the HSCA12 the PCT commissioners within the Association had begun initial discussions about tendering for an Area-wide sexual health service.

Area 2 had no comparable forum for inter-organisational collaboration. Prior to the HSCA12 sexual health services were commissioned by multiple PCTs. For example, in one locality of Area 2 there were three major providers: two large hospital Trusts (Trust 1 and Trust 2), and a large third sector organisation which mainly provided services for young people. The hospital Trusts both provided genitourinary services, with Trust 1 responsible for a bigger share of the contracted work (approximately half of all sexual health services). Trust 2 provided a smaller element of health promotion and outreach activities. Contracts for all of these services were renewed annually by the PCTs. The multitude of separate contracts for providers was reported to have led to disjointed service provision. Several interviewees reported that the services, particularly those for targeted health promotion around STIs, had not been closely reviewed for many years and were simply continuing due to systemic inertia. Furthermore, there was a general lack of co-ordination in activities between providers [9742, Area 2, LA, Jan 2016].

Post-Health and Social Care Act 2012

Theme 1: Collaboration and boundaries of responsibility

Post-HSCA12, the Association in Area 1 pursued its ambition to specify and procure an integrated sexual health service across the Area. This **collaborative commissioning approach** did not seem to represent a change of course from pre-HSCA12 developments. Moreover, one interviewee stated that, rather than facilitating collaboration, the HSCA12 had been disruptive and an obstacle to the progress that the Association had been making:

“...to be honest... all of this stuff is stuff that we would have wanted to do pre-Health and Social Care Act. ... the Health [and] Social Care Act has made it all more difficult. There's still no bright side to any of that... What's happened is that three years on we're managing to regroup and, you know, get back to where we were probably three years ago...” [14456, Area 1, LA, Jul 2016]

One LA interviewee suspected that the impetus for working collaboratively with neighbouring LAs was partially an **outcome of increasing financial pressures** (rather than specifically a result of HSCA12):

“I think this would have happened and evolved regardless of where we sat, especially if money's being reduced generally, I think we would have to work in this way.” [10944, Area 1, LA, Mar 2016]

In Area 2 the picture was different. Some interviewees stressed that the HSCA12 and the move of public health into LAs provided an **opportunity to 'reset' the landscape of sexual health provision**. One group of LAs commissioned a new service from a single provider that managed the sexual health budget and sub-contracted a range of other smaller providers, including pharmacies and third sector organisations, as well as offering an on-line STI testing service. The commissioning intention was to create a more unified, simplified service that catered better to the population at a lower cost, which included shifting more activity into primary care. One interviewee described how the move had engendered a more collaborative, holistic focus to sexual health:

“...it is taking a much more holistic social view of the people we're dealing with rather than just seeing it as one particular medical problem to be dealt with and then that's the end of that. So it was much more clinically focused before and I think now more socially focused.” [11799, Area 2, Provider, Apr 2016]

The **open access nature** of sexual health services makes it necessary for an individual patient's local commissioning body to pay for the cost of that patient's use of services irrespective of where they are accessed. Pre-HSCA12, 'cross-charging' reimbursement between PCTs for patients accessing genitourinary (GU) services outside of their local area was seen to be relatively straightforward using a Payment by Results (PbR) mechanism that was standardised across and familiar to all NHS organisations. Post-HSCA12, there was concern that **cross-charging would become problematic in Area 2** because it was not clear that LAs would respect the previous tariff arrangements, and there was no authoritative force to arbitrate and enforce payments for services used between LAs (non-NHS organisations) and providers (NHS organisations). This problem seemed to be present three years after the introduction of the Act:

“[Trust 1] will certainly try and bill [name of LA] for 50 whatever, but whether the local authority will pay up remains to be seen, because it's not clear to me who is holding the ring; whereas in the past there was a clear National Health Service understanding that you would cross-charge in this way; so it actually did happen, but getting these things to work is that, you know, you can send a bill on, it doesn't mean to say you'll ever get any money for it, it's not clear to me who is going to say to [name of LA], you must pay up.” [11799, Area 2, Provider, Apr 2016]

The financial **risks associated with cross charging were mitigated in Area 1** because all commissioners and providers had, as one of their first post-HSCA12 tasks, worked together through the area-wide Association to agree to continue with the pre-existing GU recharging arrangements as well as agreeing an additional local tariff for CASH (Contraception And Sexual Health services). The motivation to do this was to make the process of cross charging straightforward and to protect against “...a race to the bottom and people cutting services...” [8384, Area 1, LA, Nov 2015].

Other participants described scenarios which illustrated how the HSCA12 had **created confusion over the boundaries of responsibility** between organisations. This is clearly exemplified by the provision of cervical screening (smear tests), which present an overlap between sexual health services and screening services:

“[...]in the past when people have got a cervical screening letter they could go to their local GUM or CASH clinic and some areas want to take that off the offer letter... there wasn't a problem when they were doing them before it's just the money wasn't disaggregated. However local authorities have been put under significant pressure in their public health teams to reduce their budgets.” [4058, Area 1, NHSE, Jun 2015]

The overlap between sexual health services and screening appeared to present confusion around financial arrangements whereby the providers of sexual health services that now fall within the LA remit appeared reluctant to carry out cervical screening due to ambiguity about funding. The confusion around funding was particularly problematic in the early post-HSCA12 period but was still somewhat of an issue as recently as January 2016:

“But because the commissioning responsibilities and the funding are so fragmented it doesn't sit with the CCG who commission GPs as well now I think, it still sits with NHS England because it comes under screening. Or is it NHS England? Is it Public Health England and it's embedded in NHS England? It's so complicated even I can't explain it? Certainly had to meet with two different people when we went to discuss it.” [9742, Area 2, LA, Jan 2016].

Theme 2: Fragmentation of HIV treatment and prevention services

Interviewees noted that they perceived that the **commissioning and provision of HIV treatment and prevention services had become fragmented as a consequence of the HSCA12**. Post-HSCA12, LAs commission HIV prevention while NHSE commissions treatment for patients with HIV. This differs from other STI service provision, for which LAs commission both prevention and treatment (see Table 1). However, in practice, the HIV treatment commissioned by NHSE is frequently delivered by the same genitourinary (GU) consultants commissioned by LAs to deliver other STI treatments. An Area 1 interviewee explained:

“Commissioning of HIV prevention is with public health. And the commissioning of HIV treatment is with NHS England specialist commissioning. Which is completely insane because almost all of our HIV treatment is done in our GU clinics by our GU consultants... The people that we're commissioning to provide our STI services are simultaneously providing HIV services. And they're not running separate clinics to do HIV... They have to get their HIV money separately.” [8384, Area 1, LA, Nov 2015]

This separation of responsibilities for the commissioning of HIV prevention and treatment appeared to be **less of a problem in Area 2**. One major sexual health service provider reported that the sexual health services and HIV treatment services they provide were separated from each other over 10 years ago and based in different locations, which meant that the changes the HSCA12 introduced had little impact on them [11799, Area 2, Provider, Apr 2016].

The disconnection between budgets for HIV prevention and treatment appeared particularly prominent in debates regarding PrEP (Pre-Exposure Prophylaxis), a pharmacological treatment to be taken prior to sexual activity as a pre-emptive measure to protect against contracting HIV. PrEP has been shown to have high efficacy if used as directed and was recommended by the WHO in September 2015. The fragmentation of treatment and prevention seemed to fuel disagreements about whether PrEP was classed as a preventative measure, meaning that funding responsibility would lie with LAs (as argued by NHSE), or as a treatment, meaning that NHSE would be responsible for funding (as argued by LAs). In November 2016, the Court of

Appeal ruled that PrEP was a treatment and thus any funding would be the responsibility of NHSE.

At the time of writing, the NHS does not prescribe PrEP, but generic versions are available online and may be purchased legally in the UK. PrEP does not prevent other STIs and there were concerns from one LA interviewee that its use could discourage condom use and thus create a rise in other STIs, which would increase costs for LAs since they are responsible for the treatment of all other STIs:

“NHS England could say, well, actually we want it given, we'll pay for the drugs, we want it given, because it'll save them money. But we'll pick up all the treatment costs of the people going for having the extra STIs and stuff. We'll also pick up the treatment costs of people having to go to the clinics for extra screening... they might pick up some savings in HIV prevention, but... most of the cost is going to fall on us.” [8384, Area 1, LA, Nov 2015]

The fragmentation of prevention and treatment of HIV arising from the HSCA12 thus fostered an environment in which stakeholders made arguments about organisational responsibility for funding particular drugs. It also contributed to concerns that decisions or actions taken by one stakeholder may have unintended negative consequences for another stakeholder.

Theme 3: Democracy and politics

The programme theory associated with the HSCA12 for shifting public health responsibility to local government was that it would make public health more democratically accountable. One public health consultant was very positive about a change in organisational culture and a **perceived increase in democratic accountability** afforded from being part of the LA rather than the NHS. This included opportunities for increased user involvement in service design, which was felt to have made greater changes to services than would have been possible within the NHS:

“[...]it's got a democratic mandate attached to that, so you can truly decide collectively how you go about things with involving other people who you serve. You don't get that in the NHS... we would never have done what we did in sexual health in terms of having a panel of [#] young people to consider the plans for redesigning the whole sexual health system.” [10248, Area 2, LA, Feb 2016]

There was also the feeling that the **LA was a more influential partner**, able to drive change rather than simply respond to NHS-led initiatives:

“We can lead and help influence our partners in the NHS through our position on boards, our connectivity and clout in terms of reach to other services and other areas. You can actually become more of a system leader for change as opposed to a passenger within the fragmented system.” [10248, Area 2, LA, Feb 2016]

However, some other Directors of Public Health and public health consultants found that the **high levels of decision-making authority they had been afforded in PCTs were curtailed** in LAs. One interviewee suggested that Directors of Public Health and other members of the public health team now had less autonomy as LA employees because decisions had to go through local government governance processes:

“[...]we all have to come back to the ranch, we all have to come back to our local authorities[...] we can't make decisions. So it's really difficult then, for that [Association] to actually make decisions. And they don't recognise the fact that they come from a local authority, and they can't.” [10944, Area 1, LA, Mar 2016]

Furthermore, some individuals in public health teams found themselves in less senior positions in LAs than they had occupied in PCTs:

“And most public health consultants have been put into the local authorities but not at a sufficiently senior level, because there already were people in those senior levels... we don't have the seniority in the local authority that we had in the NHS... a lot of our position power has gone, both from the NHS and from the local authority.” [8384, Area 1, LA, Nov 2015]

Another LA commissioner had concerns that in the post-HSCA12 system certain sexual health services (e.g. preventative outreach work at premises frequented for sexual activity) could now potentially be more **vulnerable due to politicisation** by local councillors who believe such services should not be provided [12649, Area 2, LA, Apr 2016]. She said that public health had to be prepared to argue and fight such proposals if they appeared.

Other interviewees expressed concerns about the **bleak-looking funding landscape** of public health. Public health funding allocations to LAs are ring-fenced until March 2018, but they are being reduced year-on-year. Multiple interviewees expressed concerns that public health funding would be appropriated for purposes that stretch the interpretation of traditional public health activities because of the severity of strain on LA budgets. One public health commissioner remarked:

“...when we moved in, we joked that we'd be ending up spending our money on gritting roads as a falls prevention activity. And I think there are now public health teams who have money taken away from them to provide gritting to roads.” [8384, Area 1, LA, Nov 2016]

Another concern expressed by interviewees was that, due to the fact that they are now funded through local government, sexual health services were more vulnerable than they were prior to the HSCA12:

“... although we are delivering...NHS organisation delivering services for the NHS, we could potentially be cut back in a way that the rest of the NHS will not be. And I think that's an unintended consequence of the way the money is coming down to us through the local authorities.” [11799, Area 2, Provider, Apr 2016]

This extract highlights implications for services from changes to funding sources, whereby NHS funding and the services it pays for are more secure than LA funded services.

Summary

- In Area 1, the HSCA12 disrupted pre-existing inter-organisational commissioning practices, leading to complaints of arrested development. The existence of these practices (and the Area-wide Association which underpinned them) was felt to have mitigated some of the effects of the Act
- In Area 2, the HSCA12 was seen by some commissioners as creating an opportunity to 'reset' the landscape of provision by allowing the termination of annually renewed

separate contracts with multiple providers and the procurement of a new framework contract operated by a single provider. This new service was perceived as offering a more holistic approach to sexual health that extended beyond a purely medical model

- However, the HSCA12 appeared to have fragmented sexual health service commissioning and created confusion over the boundaries of responsibility between organisations. This was particularly problematic in the early post-HSCA12 period but was an on-going issue.
- 'Cross charging' between budget holders (either the LA or delegated provider) is difficult when there is no formal arbitrator to settle disputes. This represents a source of financial uncertainty for budget holders because they cannot guarantee they will be reimbursed when patients from a different locality use their services. In Area 1, all LAs agreed to a common tariff and specification for services to make this more straightforward and avoid a 'race to the bottom' in service offering between localities. This was facilitated by pre-existing joint working
- Sexual health overlaps with other service areas e.g. screening. There are financial implications e.g. regarding smear tests. Thus, prior to the HSCA12 women were able to seek smear tests from sexual health services as well as from their GP. LAs are not paid for providing these services, and there is some confusion as to whether sexual health services will continue to offer them
- The split in commissioning responsibilities for HIV treatment (NHSE) and prevention (LAs) creates perverse incentives, disagreements over responsibility, and potential difficulties for holistic services presenting unified messages, as seen with the funding of PrEP drugs
- Some interviewees argued that relocating sexual health services to LAs had a positive potential to increase democracy (e.g. public involvement in service design), allow for a more holistic focus on sexual health, increase the ability of LAs to influence the NHS on a more equal footing, and realise sexual health services through the more rigorous commissioning practices of local government
- However, there were concerns that certain sexual health services might be vulnerable as a result of 'politicisation' with potential for councilors to raise moral concerns in line with the perceived opinions of their constituents
- The LA funding picture is bleak. Public health funding is ring-fenced (until March 2018) but being cut year-on-year. Interviewees were anxious that sexual health services are already being disinvested in and that public health funding is being utilised for tenuously-related services.

Actionable messages

The transfer of responsibility for public health service commissioning and provision to LAs, whilst underpinned by strong arguments around democracy and the opportunity to act upon the social determinants of health, has thrown into sharp relief the areas of ambiguity around the commissioning and provision of sexual health services. In particular, it has highlighted the artificiality of distinctions between prevention and treatment, the need for close collaboration across organisational and professional boundaries and the overlaps between prevention and screening. In Area 2, the disruption associated with the HSCA12 acted to 'unfreeze' a somewhat dysfunctional system, allowing innovation and renewal. In Area 1, by contrast, a functioning system of area-wide collaboration was disrupted. Together, this evidence highlights the need for:

- Close collaboration between all commissioners and providers of sexual health-related services
- Area-wide forums within which disputes over issues relating to payment, charging and areas of responsibility can be managed and resolved

- Contracting arrangements which share risks and benefits to prevent inappropriate cost-shifting as budgets come under increasing pressure.

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