Effective Commissioning of Sexual Health and HIV Services

A Sexual Health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities

January 2003
How to use this Toolkit

This commissioning toolkit has been developed in response to the first national strategy for sexual health and HIV, and the implementation plan published by the Department of Health in June 2002. It represents a wide range of interests and views within sexual health and HIV services and aims to help and support Primary Care Trusts (PCTs) in exploring options for improving local services and the contribution they make to improving the sexual health of the population.

The toolkit has been designed for PCT commissioning leads and those responsible for leading on sexual health within PCTs, local authorities, and service providers in statutory, voluntary and community sector organisations. Strategic Health Authorities will also find this toolkit useful.

The toolkit has four main sections (including eight appendices to support the contents of those sections):

Section One – Introduction to the Commissioning Toolkit for Sexual Health and HIV Services:

introduces the main aims and objectives of the strategy, and offers an overall purpose for the toolkit and context setting to support implementation. It explains why a toolkit for commissioning sexual health services will be helpful to PCTs particularly given the breadth of services that exist across a range of providers.

Subsections include:
- Introduction
- National Strategy for Sexual Health and HIV
- Overall Purpose and Objectives of a Commissioning Toolkit
- Context Setting for the National Strategy for Sexual Health and HIV
- Why is a Toolkit needed for Commissioning Sexual Health and HIV Services?

Section Two – Establishing a Framework for the Future Development of Sexual Health and HIV Services:

acknowledges the variations of commissioning practice and skills, and provides a clear framework to support PCTs in commissioning practice, including good practice checklists and values which underpin service development and improvement.

Subsections include:
- What is Commissioning for Sexual Health and HIV all about?
- Characteristics of Good Commissioning Practice
- Checklists for Commissioning
- Values
Section Three – Developing Primary Care Trusts; Working towards better Sexual Health and HIV Services:

offers a range of models for commissioning arrangements for PCT consideration, including an emphasis on the role of voluntary and community organisations and service user involvement in service planning and delivery. Section three also provides further information on funding arrangements and reviews currently underway, and includes a section on the role of the strategic health authority.

Subsections include:

• Developing lead commissioning consortia
  – Lead commissioning role
  – Criteria for effective commissioning consortia
  – Areas to be covered
  – Four key ways for local consortia arrangements
  – Use of consortia

• Role of the Voluntary and Community Sector Organisations (VCOs)

• Involving Service Users and other Communities
  – Obtaining patient views
  – New mechanisms for service user involvement
  – Incorporating patient views

• Increased Use of the Health Act and Section 31 partnerships

• AIDS Support Grant

• Funding Arrangements for HIV Treatment and Care 2002 – 03

• Asylum Seekers and Visitors from Overseas

• Role of the Strategic Health Authority

• AIDS Control Act

Section Four – Service Policy Issues for PCTS:

Offers detailed information on improving access to sexual health services, including considerations for PCTs in relation to the provision of levels one two and three as outlined in the national strategy. It provides best practice guidance for GP, primary care, contraceptive, GUM and HIV services, and a section on tackling inequalities in access to abortion. It discusses the role of health promotion and a brief summary of the evidence base for planning and practice. Section four also discusses the roles of nurses and health advisers and the implications for training and workforce issues which need further consideration at local and national level.

Subsections include:

• Introduction

• Framework for Improving Access to Sexual health Services
  – considerations for levels one, two and three
  – local networks
  – PCT considerations for developing sexual health services in primary care

• Recommended Minimum Elements for the Provision of Sexual Health and HIV Services

• GMS Contract

• Dental Services

• Prisons

• Best Practice Guidelines for Contraceptive Services
  – Elements of a best practice contraceptive service
  – Best practice guidelines for service provision for contraceptive services
It is recommended that the lead commissioners and sexual health leads use this toolkit to identify models which best fit their local situation and tailor a model for host consortia arrangements across their area. The checklists provide detailed guidance to assist PCTs on their current position with regard to commissioning and can be used in conjunction with the local baseline review data to monitor developments and improvements as required.

Whatever choices are made locally, sexual health commissioning and service improvements will be most effective where real partnerships are encouraged across all agencies with service users, professionals and organisations working together to effect change and modernisation.

APPENDICES

These are included to provide further advice and information to PCT commissioners which will assist in developing sexual health and HIV services at local level.

- Appendix 1 Overview of Key Points in the National Strategy for Sexual Health and HIV
- Appendix 2 SW London Consortia Arrangements
- Appendix 3 Integration of the HIV/AIDS Service: South Downs Health NHS Trust Section 31 Partnership
- Appendix 4 Elements of Service for Levels One, Two and Three
- Appendix 5 Points that need Addressing when Commissioning Abortion Services from the NHS or Independent Sector
- Appendix 6 Sources of Help and Further Information for Professionals working in Sexual Health and HIV
- Appendix 7 Service Planning, Monitoring and Evaluation (including example of activity grid and ASTOR )
- Appendix 8 Example Clinical Governance Framework
Section One
Introduction

This document is intended for those responsible for commissioning and providing sexual health and HIV services in primary care trusts (PCTs) and local authorities. Strategic Health Authorities (StHAs) and service providers across the NHS, voluntary and community organisations will also find this toolkit of interest.

It provides a summary of recommended key aims, goals and standards for PCTs in relation to sexual health and HIV, and further guidance on good commissioning practice including checklists for local activity. Access to sexual health services particularly for disadvantaged groups and areas are referred to in the “Reducing Inequalities” section of “Improvement, Expansion and Reform: The Priorities and Planning Framework [PPF] for 2003–2006”. Although there are no specific targets in the PPF around sexual health services this is one of the few health areas that affects the majority of the population and is relevant through the greater part of people’s lives. The consequences of poor sexual health can have a long lasting and severe impact on people’s quality of life. Sexual health is also increasingly associated with poverty and social exclusion. It is therefore important that these issues are addressed and that quality services are in place. This document provides good practice guidance that sets out how best practice in this area can be achieved.

This guidance will be supplemented by a report setting out national examples of effective commissioning practice to be developed and published by the Department of Health (DH) in 2003.

The DH has commissioned work with key stakeholders across a range of statutory and voluntary agencies and organisations to develop and publish standards for service delivery across a range of HIV treatment, care and support services. The HIV and AIDS standards document will be available in early 2003. Further work has been commissioned for broader sexual health and sexually transmitted infections (STIs) standards (including partner notification) to be published in 2004. Details of effective managed service networks to support implementation of the standards and best practice guidance will be published in 2003.

A health promotion toolkit, a manual for health advising practice and a training strategy are also being developed and will be published shortly. This commissioning toolkit should therefore be used in conjunction with the standards documents and health promotion toolkit as they are published, as a means of providing best quality, appropriate sexual health services at local level to those who need them. All these documents will be available on the DH website.

National Sexual Health and HIV Strategy

The first national strategy for sexual health and HIV was published for consultation in July 2001 (See Appendix 1 for overview of strategy and implementation plan). It was backed by investment of £47.5 million to support a range of initiatives set out in the strategy.

The Government is committed to improving sexual health and reducing health inequalities, and recognises the direct links between sexual ill health, poverty, poor housing, unemployment, discrimination and other forms of social exclusion.
The main aims of the strategy are to:

• reduce the transmission of HIV and STIs;
• reduce the prevalence of undiagnosed HIV and STIs;
• reduce unintended pregnancy rates;
• improve health and social care for people living with HIV; and
• reduce the stigma associated with HIV and STIs.

The strategy acknowledges the breadth of challenges for improving sexual health and HIV services, which include a diverse range of treatment, care and prevention methods, and are therefore complex to commission. Services are delivered by a wide range of different providers, to meet a breadth of needs, to different populations. The cost of individual cases can be high. Demands for comprehensive and integrated contraceptive/Genito-Urinary Medicine (GUM) services are rising. Technology is developing rapidly, and the new treatments and diagnostic methods are expensive and HIV treatment costs are increasing in high HIV prevalence areas.

The average life time treatment cost for an HIV positive individual is calculated at between £135,000 and £181,000. The monetary value of preventing a single onward transmission is estimated to be between £0.5 and £1 million in terms of individual health benefits and treatment costs.

The prevention of unplanned pregnancy by NHS contraception services has been estimated to save the NHS over £2.5 billion a year.

Preventing STIs such as chlamydia will dramatically reduce the costs associated with pelvic inflammatory disease and preventable infertility. Chlamydia trachomatis infection is the most common bacterial STI in the UK and the long term consequences of infection are especially detrimental to women. It is a well-established cause of pelvic inflammatory disease (PID), ectopic pregnancy and tubal – factor infertility. It is estimated that these complications cost the NHS at least £100 million annually (Chief Medical Officer’s Expert Advisory Group). Much of this cost arises because early infection is largely asymptomatic and a large proportion of cases remain undiagnosed which leads to the later development of serious complications in untreated women.

Open access to contraceptive, GUM and HIV services remains a key priority for the treatment of communicable diseases. Therefore sexual health provision in GUM, HIV and contraception services must remain open access for service users and these services must cross boundaries between strategic health and local authorities and PCTs.

By reviewing and modernising contraceptive, abortion, GUM and HIV services, PCTs can make a significant impact on local health and well being. Even simple reforms to service provision can have immediate impact on sexual health outcomes, for example, increasing access to contraceptive training for practice nurses working from GP surgeries can increase access points for young people.

A baseline review of all sexual health and HIV services was commissioned by DH in December 2001, and will have assisted PCTs, lead commissioners and key stakeholders in identifying current strengths and weaknesses, assessing and identifying existing and unmet need, and identifying local variations in health outcomes and resource utilisation specifically for sexual health and HIV services. An analysis of these reviews will be published in early 2003.

This toolkit does not include a framework for commissioning the following services:

• substance misuse (drugs and alcohol)
• psychosexual counselling
• treatment, care and counselling for sexual dysfunction
• breast, testicular and prostate cancers
• female genital mutilation – support advice and information services
• infertility investigation and treatment
• menopause clinics
• preconceptual and pregnancy care, midwifery and obstetrics
• gynaecology, andrology, urology and endocrinology
• genetic counselling
• gender dysphoria and gender reassignment

These services interface with broader specialist and acute services, and with GP primary care.

Overall Purpose and Objectives of a Commissioning Toolkit

This document has been developed in accordance with the principles set out in the NHS Plan, Shifting the Balance of Power (StBOP) and the Planning and Priorities Framework. It has been developed as a national resource to support PCT commissioners and service providers, providing strategic direction, frameworks and models for service delivery and checklists to enable key stakeholders and decision-makers achieve the main aims of the national strategy.

Aimed at PCTs who are now responsible for commissioning sexual health and HIV services, it is not intended to be a blueprint as to how things must be done. Rather, it is intended to be used as recommended best practice guidance that can be useful and help make sense of local situations, recognising that there is ‘no one size fits all’. It aims to enable processes and mechanisms, which will lead to improvements at local level.

The six key objectives of this document are to:
• provide strategic direction
• help commissioners and providers negotiate formal agreements about service planning
• provide support to PCTs and STHAs while acknowledging that they are evolving and working within a changing environment with competing demands and priorities and limited resources
• help focus on target populations and prioritise according to needs and scope for health improvement
• where appropriate help local health economies agree achievable and measurable outputs and outcomes to self-assess progress
• facilitate the allocation of local funding within an evidence based framework.

Local action plans have already been developed in response to the national teenage pregnancy strategy, and consideration should be given to how service developments can be co-ordinated with new plans developed in response to this strategy.
Context Setting for the National Strategy for Sexual Health and HIV

The NHS Plan (July 2000) added broad expectation for joint working, seeking to ensure that the NHS and its partners work to a set of national goals and principles.

More explicitly these include:

- improved quality and access to primary care
- improved quality and access to secondary care
- narrowing the health inequalities gap between socio-economic groups with a particular focus on children
- improved efficiency of NHS services (measured by fair access, quality and responsiveness)
- increased and improved patient satisfaction with services
- improved life chances for looked after children.

Three key priorities for this agenda are:

- to ensure policy making is more joined up and strategic
- to make sure that public service users, not providers, are the focus by matching services more closely to people’s lives
- to deliver public services that are of high quality and are efficient.

Broader health inequalities are evidenced in areas of high deprivation, with sexual ill health linked to poverty and social exclusion. As sexual ill health and HIV disproportionately affects vulnerable communities, (including gay men and black and minority ethnic communities, particularly Africans), the above mentioned recommended standards should underpin the planning and delivery of interventions and services at local level to those communities.

These recommended standards also demonstrate the importance of genuinely joined up future planning so as to encompass the broad range of clinical, treatment, care and support services for people across social care and health, education, training and housing.

In summary, the modernisation of sexual health and HIV services is in line with other national policy priorities including:

- the promotion of clinical quality and service improvements
- the development of multi disciplinary and multi-agency partnerships
- improved access to quality services for treatment, care, support and health promotion
- targeted health promotion interventions, including outreach and information
- a reduction in health inequalities
- bridging the gap between health and social care provision of services
- increased contribution from GPs and practice/school/community nurses and health advisers
- the development of more patient centred services with greater user and community participation in service planning and evaluation.
Commissioners and providers will need to stay abreast of national initiatives to improve the quality of health and social care where these may impact on sexual health services. These will include the national service frameworks where commissioners will need to ensure that their activities contribute to improving sexual health wherever possible. For example, it is anticipated that the forthcoming National Service Framework for Children will incorporate elements to address sexual health issues amongst young people. The National Service Framework for Diabetes also highlights the long term implications of the disease for sexual health (the management of erectile dysfunction).

Why is a Toolkit needed for Commissioning Sexual Health and HIV Services?

“PCTs will want to use their local commissioning discretion to reshape how local health care services are delivered to reduce waiting times, increase responsiveness and improve clinical outcomes. They will want to ensure a focus on prevention services as well as treatment, to forge local partnerships to more effectively address health inequalities and ensure an appropriate balance between investment in primary and community services as well as acute.”

(HSC 2002/007)

Securing Service Delivery: Commissioning Freedoms of Primary Care Trusts

Feedback from the strategy consultation suggests variations in commissioning practice. Many service patterns are characterised by historical patterns of spending and may not have been updated by evidence from local needs assessments or epidemiology. Commissioners of sexual health and HIV services are at different levels in their development, particularly with recent reforms as a result of StBOP, and the move from former health authorities to PCT led commissioning.

PCTs will need to take active steps to manage increasing demand and the implementation of new technologies. Though a simple concept, this may prove to be a complex process to implement in practice, not least because of organisational change, but also because its requires new structures, new systems and changes of role across PCTs and clinical, support and prevention services. The commissioning process will also require the development of new relationships and new attitudes to decision making amongst those involved.

This toolkit has therefore been developed as a national resource for sexual health and HIV commissioners and service providers, recognising that some areas will have already established excellent commissioning principles, and others may currently be developing them.
Section Two

Establishing a Framework for the Future Development of Sexual Health and HIV Services

PCTs can consider a strategic approach to support progressive development for sexual health work at local level. This includes identifying clear stages in partnership relationships and major factors that will impact on the commissioning process.

Commissioners will need to pinpoint their local strengths and weaknesses and opportunities for change in service provision, and consider further approaches that can be useful in identifying expertise to enable this to happen locally. Some examples of key elements for consideration for commissioning are given below, derived from work undertaken by fpa on service commissioning. They include:

commissioner culture and expertise

– the way in which the role of the commissioner has been developed, the clarity with which the commissioning processes are defined, and the skills held individually and organisationally

needs assessment

– the foundation variable, (i.e. needs assessment is the most effective method to determine the sexual health needs of communities)

strategic planning

– defines how the future of sexual health and HIV services will be configured, how they may differ from current arrangements and suggests clearly defined milestones toward key priorities

user involvement

– beyond tokenistic consultation, it should mean the engagement between commissioners, service providers and users that will impact on the outcomes as well as shaping priorities and strategic planning. User involvement, to be effective, should be a thread running through the commissioning process, and as such should adopt a variety of methods to encourage participation and involvement from service users

communication

– focuses on the exchange of information and dialogue between stakeholders and the use of and relationship with the media and other forms of information sharing with the public
primary care focus
– recognises the major impact of ‘Shifting the Balance of Power’, and the move to primary care led commissioning where influence on the direction, quality and quantity of sexual health provision will be determined

resources
– the allocated finance and staff resources from all sources which will drive the provision of relevant services, and which must be used creatively to add value and develop services in the right direction

collaborative working
– which should reflect the range of stakeholder interests and recognises that much more will be achieved through partnership approaches and strategic and financial alliances

education and training
– which needs to be provided to support successful implementation of the strategy’s action plan, support professionals and enhance understanding and expertise at local and national level

building relationships
– including formal and informal mechanisms which strengthen effective relationships between commissioners, providers, users and communities

building local networks
– identifying the local champions that will make most impact, and identifying the range of interventions and validating them.

To develop effective PCT commissioning, there are steps that can be taken to create the right climate for changes and/or improvements in current practice. This includes an understanding and definition of what commissioning actually is.

The following section outlines the characteristics of good commissioning practice and checklists for improving local services.

What is Commissioning for Sexual Health and HIV all about?

Commissioning, purchasing and contracting are not the same activity, despite the terms often being used interchangeably.

“The purpose of commissioning is to maximise the health of a population and minimise illness by purchasing health services and by influencing other organisations to create conditions which enhance people’s health.”

(Ouvriet, J Purchasing for Health – Oxford Uni Press 1995, p.18)
Purchasing health services is a narrower activity, one that is concerned with buying the best value for money services to achieve the maximum health gain.

Contracting is simply the selection of a provider and the negotiation of an agreement to provide an appropriate quantity and quality of service of payment.

PCTs will approach the challenges according to their locally identified needs assessments and epidemiology, and will address them in different ways. However, whichever approach is taken, good commissioning requires:

- Relevant and appropriate information about local service provision
- Systematic choices within and between services
- Strong partnership arrangements with key stakeholders and providers across a range of agencies and organisations in the statutory and voluntary sector.

Although the definitions clearly delineate these activities, they are in fact linked processes. Key commissioning processes are therefore the set of activities that provide a tangible connection between the assessment of need within the target population, and the delivery of health outcomes.

The Linked Process

These key processes are cyclical. Outputs and outcomes will ultimately inform the ongoing assessment of need. What is learnt from the process should also be identified and incorporated into day to day practice.
The key commissioning processes for sexual health and HIV services will therefore include:

- needs assessment
- consider developing local strategy plan based on of the national action plan
- local priority setting dependent on need and epidemiology
- local plans agreed across consortia and/or partnership boards
- specifications for service delivery with all service providers across treatment, care, prevention, health promotion and support
- service level agreements with the range of statutory and voluntary providers
- service monitoring and evaluation to ensure progress to recommended standards
- outputs and outcomes against success criteria outlined in service level agreements (SLAs)
- outputs and outcomes against the success criteria in local strategy and action plans.

(Appendix 7 provides details of good practice for service planning, monitoring and evaluation, including examples of ASTORS and activity grids)

Characteristics of Good Commissioning Practice

For tighter and more effective responses and to encourage closer collaboration across agencies and organisations (to improve service delivery and to provide more seamless services), the following characteristics are considered good practice:

- agree formal Board level commitment to reviewing sexual health services
- develop a joint vision for the future planning and delivery of services
- establish the gap between the vision and current service provision by reviewing local services
- identify available resources
- develop and implement local needs assessment programme
- identify local needs against epidemiological data and establish information systems to collect better information that can inform future planning
- review local service provision
- identify gaps in provision
- identify areas for improvements and prioritise those service developments according to shared vision
- establish clear arrangements for joint commissioning within the area ensuring that any joint arrangements are linked to each partners mainstream activities and budget processes
- establish stakeholder arrangements
- promote effective links between key stakeholders (GUM, contraceptive services, young people’s services etc) to ensure cohesion
- consider the development of health promotion strategies to promote the engagement of socially excluded groups and improve access where problems are apparent e.g. targeted services for gay men, or African communities disproportionately affected by HIV, or young people’s services to
increase uptake of chlamydia screening, emergency hormonal contraception, and STI testing (see health promotion toolkit)

• develop more effective assessment, care planning and co-ordination arrangements to ensure that the services provided match the client’s level of need
• promote more multi-disciplinary processes including single assessment and single points of access into the range of services, thus minimising the risk of ‘revolving door’ syndrome (i.e. services users being referred on unnecessarily)
• improve the quality of support available to those target groups most affected by sexual ill health, particularly those with complex or intermittent problems
• strengthen joint working arrangements and establish multi-disciplinary teams where possible
• review effectiveness of shared care arrangements, taking into account the strengths and weaknesses of different models, new funding flexibilities, and the views of key stakeholders and service users across the range of providers and users
• review current funding provision in acute NHS Trusts and PCTs and ensure that levels of expenditure accurately reflect user needs and support
• consider the development of consortia arrangements across strategic health authority and PCT areas where patient flow warrants it and where warranted by economic factors.

Recommended Checklists for Commissioning

Strengthening partnership working and commissioning

• set up inter-agency planning fora at local level to oversee the needs assessment and commissioning of sexual health and HIV services
• identify a lead person within the PCT responsible for liaising with the lead commissioner for Sexual Health. This could be one and the same person or a different person depending on whether host commissioning consortia are in place
• consider the establishment of host consortia arrangements across Strategic Health Authority areas
• ensure the use of Section 31 partnership arrangements are linked to provider partner mainstream activities and budget processes
• establish effective links between planning fora and other key strategic partnerships into the commissioning process, including service user views
• promote greater emphasis on long term planning and funding cycles to promote better continuity in local service development
• provide clarity around expectations and clear statements as to who is responsible and accountable for each work or service provision area
• accumulate evidence of effectiveness of interventions and programmes, and use ASTORS (see Appendix 7 for explanation of ASTOR) to develop appropriate outcome measures of impact (also see CHAPS and Making It Count framework, managed by Terence Higgins Trust)
• share good practice and evidence of effectiveness.
**Promoting better care co-ordination and joint working**

- develop a shared understanding of local needs assessment and identify priorities of what needs to be done to improve care locally
- define the roles and responsibilities of the different services and identify who will take the lead in driving forward new care planning arrangements
- establish and agree clear criteria for referrals between services and how they will be dealt with. Include the criteria in Service Level Agreements (SLAs)
- set clear criteria and common procedures for assessment to reflect a multi-agency, disciplinary and integrated approach
- agree training and development needs arising from the introduction of new arrangements and how these will be addressed
- consider how users could be involved in developing those services.

**Developing more flexible approaches**

- strengthen sexual health services across the range of providers to enable flexibility according to local needs identified by providers and users
- introduce shared guidelines, protocols and procedures with partners across the range of service providers.

**Improving support to primary care**

- assess the elements included within the 3 levels for service delivery set out in the strategy, and identify local specialist and primary care providers of these levels
- introduce a local shared care policy (where relevant) agreed with clinical governance leads within acute trusts and PCTs
- introduce parallel care for patients with stable quasi chronic conditions
- take account of the views of GPs and other stakeholders including the Local Medical Committee (LMC) and PCT on the introduction of a shared care scheme
- consider further the role played by practice, community and school nurses and health visitors in supporting vulnerable patients, and ensure adequate training and support for nurses wanting to develop their sexual health promotion role
- identify wider training implications for primary care providers and consider resources available to support training needs.

**Values**

PCTs should make explicit the values which underpin their local sexual health service provision and development and can encourage providers and users together to make effective interventions for sexual health gain. Explicitly stated values are considered important particularly for sexual health services as concerns about stigma and discrimination for people with HIV and other STIs, and/or women seeking abortions are widespread and affect access to relevant services. Anonymity and confidentiality are key indicators for successful access and uptake of services, and for respecting people's rights to dignity and privacy, so explicit values may improve confidence and consequently uptake of services.
Some values that PCTs may consider useful in developing with providers and users are as follows:

**Equity**

People need access to services of quality, appropriate to their needs, regardless of race, gender, sexuality and religious and cultural beliefs. Services could offer opportunities for significant improvements in health, including reduction in diseases and disorders, and promote well being to all users, applying principles outlined in the health promotion toolkit. Commissioners and providers should recognise the interplay of other social and political factors in relation to sexual health.

**Accessibility**

Services should be clearly advertised, welcoming and accessible to those who need to use them. They could encompass the needs of diverse communities, and make them accessible to meet those needs, including those for who English is not their first language.

**Participation**

Services can encourage and enable users and carers to participate in the life of the community in which they live. Information on and referrals to other agencies, organisations and/or groups in the local area facilitate participation for service users. Where possible, user feedback can be fed into the commissioning process, via service providers.

**High Quality and Best Value**

Services should be provided at high quality and at the best value within available resources.

**Positive Image**

Services need to recognise that people seeking sexual health services may find it difficult to ask for assistance with some issues. They could ensure that the service views both itself and its service users in a positive light.

**Effectiveness**

Services can be encouraged to look at evidence of effectiveness in relation to their service delivery, and ensure that this is monitored and evaluated as part of the service level agreement monitoring.
Appendix 1

Overview of key points in the National Strategy for Sexual Health and HIV

The aims of the national strategy are outlined in the introduction.

The strategy and subsequent action plan proposes to achieve these aims by:

• providing clear information so that people can take informed decisions about preventing STIs, including HIV
• developing a new information campaign for the general population
• producing a sound evidence base for effective local HIV/STI prevention
• developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers
• collaborating to plan services jointly so that they deliver a more comprehensive service to patients
• evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;
• beginning a programme of screening for chlamydia for targeted groups in 2002
• stressing the importance of open access to GUM services and, over time, improving access for urgent appointments
• ensuring access to a full range of contraceptive services are provided for those that need them
• addressing the disparities that exist in abortion services across the country
• increasing the offer of testing for HIV to ensure earlier access to treatment for those infected and limiting further transmissions of the virus
• increasing the offer of hepatitis B vaccine
• setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV
• setting priorities for future research to improve the evidence base of good practice in sexual health addressing the training and development needs of the workforce across the whole range of sexual health and HIV services.

Immediate priorities identified in the implementation action plan are:

• publication of commissioning guidelines and a health promotion toolkit
• publication of a training mapping and strategy report and recommendations
• disseminate evidence of effectiveness for HIV and STI prevention
• improve the quality of national helplines
• publication of African HIV frameworks for prevention and care services and new model of delivery for national African HIV health promotion led by the voluntary sector
• roll out of the chlamydia screening programme to 10 areas
• appoint to an Independent Advisory Group to facilitate national implementation
• publish HIV service standards
• commission further standards for broader sexual health
• launch new sexual health information and awareness campaign
• roll out the HIV prejudice and discrimination campaigns
• improve information and advice available to the public on sexual health
• monitor investment and progress on the strategic implementation national.
Case Study – The South West London HIV & GUM Commissioning Consortium

The South West London HIV & GUM Commissioning Consortium was established in May 1999 as a joint initiative between Kingston & Richmond Health Authority (K&RHA), Merton, Sutton & Wandsworth Health Authority (MSWHA) and Croydon Health Authority (CHA), and is responsible for assessing need, developing strategy and commissioning GUM and HIV services for South West London. This built on previous joint working by the three HAs in conjunction with five of the corresponding Local Authorities, namely: Kingston, Richmond, Merton, Sutton and Croydon in the commissioning of HIV voluntary sector services since this responsibility had been devolved by the former South Thames (West) Regional Health Authority in 1994.

Following the changes in the NHS in April 2002, the Consortium was retained by the successor bodies to the three HAs and now works on behalf of the five Primary Care Trusts (PCTs) within the boundaries of the South West London Strategic Health Authority (namely: Croydon PCT, Sutton & Merton PCT, Wandsworth PCT, Kingston PCT and Richmond & Twickenham PCT).

The Consortium, based in Croydon, is managed by a steering group of commissioning, finance and public health personnel from the participating PCTs and is staffed by 0.6wte Consortium Manager, 1.0wte Commissioning Manager and 1.0wte Contracts & Information Officer.

A Prevention Advisory Group (PAG), made up of health promotion specialists from across SWL, facilitate a co-ordinated approach to HIV Prevention and advise the Consortium on HIV prevention needs and services.

During 1999/2000, two additional groups were established, an HIV/GUM Consultant and Service Managers’ Forum and a Specialist HIV Pharmacists Group. These fora helped to facilitate a sector wide approach to the delivery of services by benchmarking services, developing standards and looking at service developments in line with a sector model. These groups were key to the establishment of the South West London HIV & GUM Clinical Services Network, which covers all of the HIV and GUM Services in South West London (Mayday, St. Georges, St. Helier, Queen Marys and Kingston).

The consortium arrangement is coterminous with the local StHA and with the local HIV and GUM clinical network and this is beneficial in that it covers a defined health economy area. The consortium also represents the interests of South West London in London-wide commissioning arrangements through the London HIV Consortium.
How services work in South West London

Commissioning of hospital based services:
• contracts are negotiated by the Consortium based at Croydon PCT
• contracts are hosted by lead PCTs
• finance is mapped between PCTs to resource hosted contracts
• services are performance managed and co-ordinated by the Consortium.

Commissioning of community services:
• responsibility of individual PCTs
• consortium influences strategy relating to community services.

Commissioning of voluntary sector services:
• consortium meets with local authority commissioners to develop and agree joint commissioning principles and intentions
• contracts are negotiated and hosted by the Consortium based at Croydon
• finances are held by the Consortium.

Strategy
• Consortium acts as the strategic lead on HIV and GUM service issues
• Consortium develops HIMP and SAFF sections on HIV for each local Health Economy.

Information
• Consortium acts as a point of reference/contact for information on HIV and GUM issues
• Consortium developing a framework for HIV service user involvement across the sector covering statutory health and local authority and voluntary sector services.