Case for Change in Governance arrangements of the London Sexual Health Commissioning Board

1. Aim

This paper outlines the reasons to strengthen the governance arrangements for the London Sexual Commissioning Board (LSHCB) in its leadership role of Sexual Health Commissioning for PCTs in order to improve Sexual Health in London. It is supported by the PCT CE lead on Sexual Health and endorsed by the LSHCB.

2. Background

2.1 Needs

London continues to have the highest rates of Sexual Ill Health in the UK and in Western Europe. The first London Sexual Health Service Mapping and Needs Assessment report, Sex and Our City (2008) showed that these rates have remained at the same high levels for over 3 years.

In 2007, London had the highest number of sexually transmitted infections (STIs) recorded in England. Around two in five diagnoses of infectious syphilis and gonorrhoea, more than one in five diagnoses of genital Chlamydia and genital warts, over a quarter of herpes diagnoses and half of HIV diagnoses were made in the capital. London continues to have one of the highest rates of teenage pregnancy in Western Europe and the highest rates of abortions and repeat abortions across all age ranges in the UK.

2.2 Performance

London PCTs are amongst some of the best and most challenged in delivery of Sexual Health performance targets. London PCTs achieved the 48hr GUM access target by March 08 but have not sustained this into 2008-9. London PCTs are meeting the access to NHS abortion indicators but continue to have levels of contraceptive uptake that do not meet NICE guidelines (2005). Most London PCTs are not on course to achieve the Chlamydia screening or teenage pregnancy targets. There has been much progress against the London HIV prevention performance target but over 35% of PCTs are not within their 2007 trajectory by >5%.

2.3 The London Sexual Health Programme

The London Sexual Health Programme (LSHP) was set up in 2005 by the 5 SHA Chief Executives in order to lead Sexual Health Commissioning and improve Sexual Health outcomes. Its initial aim was to deliver the London Sexual Health Framework (2004) that set the Quality framework and standards to improve Sexual Health in London.

Since then, the London Sexual Health Programme has transferred to PCTs within the umbrella of the London SCG. It has achieved many outcomes and firsts including:

- Supporting achievement of the 48hr GUM access performance target.

- Supporting dehosting and cross charging of GUM in London, which remains only one of two SHA areas to implement PbR for GUM, despite this being the third year of its introduction.

- London-wide model framework commissioning tools including GUM, contraception and abortion commissioning guidelines and service specifications. These are based on models of best practice and supported by various Royal Colleges.

- Levering over £300,000 in 2008-9 from DH and uniquely the Private sector to strengthen World Class Commissioning of Sexual Health Services with London first's Sexual Health Needs Assessment, Sex and Our City; and £150,000 Private sector funding for a mobile training team
in Primary Care to increase skills to provide LARCs.

- Leading a learning set on Sexual Health Commissioning to strengthen skills and competencies in PCTs

- Developing tariffs for post exposure prophylaxis following risky sexual exposure (PEPSE) and being the DH's PbR improvement project to develop an integrated Sexual Health tariff.

- Leading the development of the London HIV prevention performance target, the first of its kind internationally, that aims to reduce morbidity and mortality by reducing late diagnoses of HIV by 50% over 3 years.

The LSHP works with the PCT CE lead on Sexual Health who chairs the LSHCB.

3. Reasons for change

The governance arrangement of the LSHCB needs to be strengthened. The Board is advisory to PCTs and much of its guidance based on best practice is not implemented by PCTs. This leads to commissioning that shows inequitable access to quality Sexual Health services, wide variation in funding that is not linked to needs and lack of use of basic contracting tools. Quick wins that improve Sexual Health and lead to financial savings to PCTs are not being implemented. Although there have been many achievements in PCTs, the Sex and Our City report notes that:

- despite the development of a London Contraception Plan outlining high impact changes that can deliver improved access and choices to contraception to women, there is large variation in access and funding of contraception for women by PCT of residence. A London business case to increase access to LARC that would achieve the NICE guidelines (2005) and give a net saving to PCTs of £17m was endorsed by the LSHCB in July 2008 for PCTs to use but it remains outside of PCTs' commissioning intentions for 2009-10. Likewise, LSHP provided best practice guidance on achieving the Chlamydia Screening target to PCTs that included funding a Pan-London information officer to retrieve screens in the community. This would only cost each PCT c£2,000 per year and would improve performance by 2-3% more screens across London. This has not been agreed by PCTs.

- less than 50% of PCTs are using the framework contracting tools developed by the LSHP e.g. GUM service specification

- despite the development of a London tariff for PEPSE, none of the PCTs have agreed to use this which means PCTs are not meeting the CMO's letter stating the need for PEPSE to prevent the transmission of HIV

- despite the London commissioning guidelines on abortion being in place and noted as an example of best practice by the Royal College of Obstetrics and Gynaecology, there remains large inequity in access to quality abortion services across London PCTs

The Sex and Our City report outlines the need to strengthen commissioning of Sexual Health at local, sector and London-levels. Without this, Sexual ill Health will remain a major Public Health and financial challenge for London costing a minimum of 3% of the Capital's NHS resources (excluding Primary Care costs).

3.3 Opportunity to improve Sexual Health in London through commissioning

This case for change gives PCTs the opportunity to strengthen the commissioning of Sexual Health services. The LSHCB's work is based on evidence of effectiveness and best practice so that PCT commissioning is "done once and done well" to avoid duplication of effort and resources. It provides consistency of commissioning to achieve better outcomes with equitable access and provision of services.

The following options are proposed for the London Sexual Health Programme and Commissioning Board:

3.3.1 Do nothing

3.3.2 Integrate it as a formal consortium of the London SCG and its Establishment Agreement with PCTs

3.3.3 Integrate it into the London HIV consortium

3.3.4 Integrate it into the formal Healthcare for London workstreams so that it can use its infrastructure and levers.

3.3.5 Integrate it into the proposed NHS London's Framework Prevention Programmes

3.3.6 Integrate it into the "Hub"

3.3.7 Other options?

4. Options analysis

An options analysis is attached.

5. Financial implication

This case for change is cost neutral to PCTs who are already funding LSHP. No additional funding is required.

6. Recommendation

The option to do nothing would not strengthen Sexual Health commissioning in London. As the LSHP is hosted by the London SCG, it is proposed that the LSHCB is integrated as a formal consortium of the London SCG.

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Options analysis: Case for Change in the governance arrangements for the London Sexual Health Commissioning Board

Options	Advantages	Disadvantages	Comments
1. Do nothing	1.1 LSHP has been established within the SCG for nearly 2 years. This enables synergy and close working with the HIV consortium.	1.1 Sexual Health is not a specialised service and may not be perceived to be within SCG remit. 1.2 Improved Sexual Health commissioning, quick wins and savings are not achieved as quickly as they could be. The lack of consistency and access to and funding of services will not be addressed.	The LSHCB and LSHP will continue to advise PCTs that may not take account of its work.
2. Formal consortium within London SCG	2.1 There is formal accountability for the LSHCB work programme via the SCG to PCTs. 2.2 LSHCB decisions will be actioned using the SCG Establishment Agreement and structure with PCTs e.g. working with the SCG and 5 Sector Divisional Directors.	2.1 Sexual Health is not a specialised service and may not be perceived to be within SCG remit.	Formalising the LSHCB as a mainly Strategic Planning consortium (with some procurement) of the SCG embeds its work with a clear Pan-London commissioning model.
3. HIV consortium	***3.1 Sexual Health and HIV treatment and care are strategically linked and integrating with the HIV consortium would support greater synergy of their commissioning.***	***3.1 The scale of the HIV consortium's work and commissioning is too large for one joint consortium to address Sexual Health as well.*** ***3.2 Sexual Health commissioning involves a different range of users,***	***3.1 It would be a challenge to manage a Sexual Health and HIV consortium meeting as the business for each is already large. There will need to be separate meetings with different membership for Sexual Health and HIV treatment and***

		services and stakeholders than those in the HIV consortium.	***care. Individual Sexual Health and HIV consortia would be more manageable.*** ***3.2 Synergy and close working between Sexual Health and HIV treatment and care is achieved with the LSHP Director and the Lead commissioner for HIV being members of the LSHCB and HIV consortium.***
4. Healthcare for London	4.1 Healthcare for London is a priority for the NHS in London and Sexual Health would be integrated into its strategic planning, implementation and governance arrangements. 4.2 There are more opportunities for synergy and added value in working with the Healthcare for London structures and staff e.g. developing care pathways, work on polyclinics and focus on self management.	4.1 Sexual Health may be considered a low priority within Healthcare for London's work programme.	
5. NHS London's Prevention Programmes	5.1 LSHCB and LSHP would be within the Strategic Public Health role of NHS London with its advisory role to the Mayor for Health Inequalitites. 5.2 Sexual Health "fits" within a	5.1 LSHCB may be perceived to be more SHA-focussed than PCT business.	This options strengthens links with NHS London's Public Health role and places the work within the London framework for Prevention.

	Preventative framework and would align well with other programmes under NHS London. This is the model in other SHAs. 5.3 The LSHCB and LSHP could be better place to lever in the performance and other roles of NHS London.		
6. “Hub”	6.1 LSHCB would be under the governance arrangements of the “Hub”. 6.2 LSHCB’s supportive role to improve PCT commissioning fits within the aims of the “Hub”.	6.1 The “Hub” advises and supports PCTs. This would not enable the “traction” needed by the LSHCB.	There are synergies is some of the functions of the LSHCB and LSHP with the roles of the “Hub”.