Future Commissioning of London HIV Prevention Services
Project Steering Group

Stakeholder Engagement Report

This report was commissioned by The Association of Directors of Public Health (London) and written by Jane Mezzone, Vikki Pearce, Fraser Serle, Pam Skuse, Paul Fraser Associates

LONDON COUNCILS

In February 2013 the Leaders' Committee at London Councils recognised the shortcomings of the Pan London HIV Prevention Programme (PLHPP) approach to HIV prevention. In response, the Association of Directors of Public Health (ADPH) London, working with London Councils, designed the Future Commissioning of London HIV Prevention Services (FCLHPS) Project to oversee a London-wide needs assessment over the summer of 2013. The FCLHPS project included six work streams:

- Epidemiological review
- Evidence review update
- A Call for Evidence
- Stakeholder engagement
- Segmented insight research
- Mapping of current HIV prevention.

The overall findings of the needs assessment are published in the report: "HIV Prevention Needs Assessment for London" (November 2013). This report is the output of one of the six underpinning work streams, and focused on the stakeholder engagement. ADPH London and London Councils will develop an options paper for a meeting of the leaders of the 33 councils in London, due to take place in November 2013.

THE FUTURE COMMISSIONING OF HIV PREVENTION IN LONDON

Stakeholder Engagement Report

A REPORT FOR THE LONDON DIRECTORS OF PUBLIC HEALTH

September 2013

Jane Mezzone, Vikki Pearce, Fraser Serle, Pam Skuse

PAUL FRASER ASSOCIATES

ACKNOWLEDGEMENTS

Paul Fraser Associates would like to thank all the participants in this stakeholder engagement process. Their contributions have been invaluable and offer an insight and experience required to inform decisions on the future of HIV prevention in London.

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EXECUTIVE SUMMARY

The following activities were undertaken to elicit views from the widest range of stakeholders feasible within the timeframe allocated:

- A series of one-to-one and small group stakeholder interviews
- A series of telephone stakeholder interviews
- An online questionnaire which was distributed across all London commissioners
- A Call for Evidence
- Stakeholder events, including the London sexual health commissioners and a large scale multi-organisational stakeholder event
- Seminar organised by the South West London Network lead
- Use of the London Councils website and newsletter email list twhich encouraged wider participation and feedback

The delivery team acknowledge that some stakeholders may not have been able to participate due to short time frames. The stakeholder engagement provides a narrative as well as acting as a source of expert opinion.

There was general agreement that the HIV prevention services currently provided in London are based on historical models. As part of this engagement process, there was enthusiasm for a more holistic approach to the public health interventions, which should now encompass a broader range of health determinants, including substance misuse, smoking cessation and alcohol use.

In terms of the future model, many stakeholders cited the Marmot review, (Fair Society, Healthy Lives 2010) into health inequalities stating that it gave a broader and more relevant context to risk. The majority of stakeholders were clear that there were missed opportunities by having such a narrow definition of HIV prevention for people's health seeking behaviour.

WHAT HIV PREVENTION NEEDS TO BE PROVIDED

A combination approach, rather than one universal approach, to HIV prevention recognises the range of factors that influence an individual's relationships and safer sex behaviour. It also offers a menu of interventions with clear patient pathways and strong referral processes needed to enable providers to meet the different needs of individuals. HIV testing is an effective primary clinical prevention initiative, and HIV treatment is an effective secondary clinical HIV prevention initiative; however, they cannot be delivered in isolation. The division between primary and secondary prevention work is deemed unhelpful.

HIV testing as the means to an end is seen as a limited approach without the back up of behavioural change interventions to add value and support the individual. HIV negative diagnoses are often missed opportunities as more attention needs to be given to health promotion interventions for individuals to remain negative. There is an opportunity to introduce HIV testing in a broader range of community and primary care settings and a need to incorporate much broader risk factors into the intervention portfolio (including alcohol and drug use).

The availability of consistent quality information and resources is regarded as central to HIV prevention. There is an overwhelming sense that HIV prevention is failing to evolve at the same speed as societal changes and that embracing new technology is far too slow

and ad hoc. There is no consensus on the effectiveness of mass HIV prevention media campaigns. The reach of campaigns is generally limited by size of budget. There are high levels of social media use amongst both gay men and African communities although patterns of usage were different.

It is acknowledged that people like to access information about health and available services in an anonymous and confidential manner and that new technology can facilitate this. However, without some form of co-ordination the potential for duplication is a waste of time and resources. Any London wide HIV programme need to compliment HIV Prevention England activity would see all boroughs agreeing on the key messages to deliver at the same time; however, the methodology for delivering the messages could be targeted to local needs.

It is recognised that interpersonal (face to face) interventions help people make healthier life choices, including reducing risk taking behaviours. Interpersonal interventions acknowledge the complexities of individual lives which clinical/medical models and population based approaches do not; however, they are time consuming and expensive. The push to increase HIV testing as a prevention tool was seen as potentially undermining the individual 'one to one' interventions. 'Warm referrals' offer a solution to the lost follow-up; stipulating this and joint working arrangements in Service Level Agreements (SLAs) between clinical and third sector organisations can facilitate better patient pathways.

The availability of condoms and the promotion of their use was seen as an essential HIV prevention intervention. There were a significant number of stakeholders who felt that messages about promoting condom use had faded and that there needed to be more high profile promotion of their use.

Better value for money could be achieved by using one centralised purchasing system for condoms, increasing Council purchasing power. At present there are a plethora of local free condom distribution schemes targeting different populations: gay men, African people and young people as well as the Pan-London freedoms scheme (which distributes condoms to gay venues) and C-Card schemes for young people.

Businesses where sex on premises is known to occur need to make a bigger contribution, with the provision of free condoms being made a requirement of their licence agreements.

Almost all stakeholders cited the lack of consistent PHSE in schools as a gap. Young people in London are learning about sex from the Internet and therefore there is no way to ensure that they are getting factual information. The need to educate young gay men about safer sex was a particular concern considering the HIV prevalence rates in London.

HOW TO DELIVER HIV PREVENTION FOR LONDON

Most stakeholders were concerned as to how to better align clinical service provision with the HIV prevention agenda, with the role of GUM and community clinics in HIV prevention increasing. Given that London councils are now responsible for commissioning GUM services, there are major opportunities to improve the role of GUM in HIV and STI prevention and to identify additional and alternative settings to increase uptake of HIV/ STI testing.

There was overwhelming consensus from stakeholders that there needs to be a lead commissioning HIV and Sexual Health coordinator for London with the formal delegated responsibility to support all 33 London councils. They would work closely with public health leads, policy organisations, third sector organisations, the London local area teams at NHS England and service users, in order to develop a robust, strategic, evidence based commissioning plan for London.

There is a sense that present commissioners are "**too reliant on the perceived wisdom of current providers"**, and that this needs to be addressed to reassure providers that there will be strong accountability for decision making and governance arrangements. Commissioning needs to address the 'Broader Determinants of Health' and be less 'siloed' into individual health topics.

Some stakeholders expressed concern that there was little incentive for local authorities to prioritise HIV prevention as they will not be responsible for the lifetime drug costs for those living with HIV. HIV treatment and care costs are the responsibility of NHS England.

Stakeholders agree that commissioners should clearly define their expectations, defining excellence and setting the parameters for providers. This will rely on excellent communication channels with robust SLAs used to monitor and evaluate the purpose, outputs and outcomes of a range of interventions. SLAs need to encompass identified cultural norms, and challenge perceived wisdoms, and could have an element of evaluation development as well as a standard evaluation framework. SLAs should specify that clinical providers engage with third sector providers, and include joint working with accessible and seamless referral pathways.

There was universal consensus on the need for an integrated tariff for sexual health services, including HIV testing, especially now that there are major opportunities to address HIV and sexual health at one clinical intervention point. This would help local councils know they were paying like for like, especially with the opportunities to provide integrated services across GUM and reproductive health.

There needs to be consistency in the methodology used to evaluate the effectiveness of HIV prevention methods. Stakeholders felt that this could be developed in partnership between public health and providers. There was recognition that a standardised tool was not applicable to every aspect of delivery but that SLAs could take account of any local borough variations. A sexual health balanced scorecard could be introduced as a standardised tool with local metrics to account for variations.

There was also a clear message from stakeholders that the data collated should be used to inform any future commissioning intentions. A transparent process would be welcomed in order to allow for flexibility and programme development on a borough, multi-borough and London wide basis. Service user voices should be actively encouraged as part of the data collection, and providers should foster a culture that encourages and enables those voices to contribute and to be heard.

CHALLENGES

Stakeholders believe assumptions on the homogeneity of gay men, men who have sex with men (MSM) and African communities are unhelpful. However, there was consensus that interventions and activities specifically targeted should remain a priority for future commissioned HIV prevention. Migration into London poses particular challenges, with new cohorts of gay men and African people arriving.

Gay venues are no longer the predominant way in which gay men socialise. Smart phone apps designed for men to meet for sex are increasingly popular, with MSM able organise and access sex in the borough in which they live with ease. There needs to be far greater partnership work developed to address the complexity of drug and alcohol use amongst MSM.

It was thought that stigma and discrimination continues to play a major role in late diagnoses. An absence of disclosure, lack of consistent condom use and, for many women, domestic violence associated with HIV disclosure all need to be addressed. Creating consistent support within local communities at risk of HIV is seen by the majority of stakeholders to be an important part of an effective HIV prevention programme

There was a clear message from stakeholders that political will is required to ensure consistent provision of PHSE/SRE, particularly for young gay men/MSM.

Stakeholders identified a need to review the current commissioning arrangements for GUM/sexual health services and their role in HIV prevention.

CONCLUSIONS

In determining what is now required for future HIV prevention commissioning in London, stakeholders suggest revisiting the menu of interventions, and the financial allocations and allowing for increased flexibility in programme development. Stakeholders see a need to use broader London wide risk prevention strategies that take advantage of economies of scale and directly acknowledge the broader determinants of health in individual's lives. This must include information and targeted support on substance misuse, smoking and alcohol.

In summary HIV prevention in London needs to:

- Prioritise the prevention of poor sexual health;
- Have strong leadership and joined up working;
- Focus on outcomes;
- Address the wider determinants of sexual health;
- Commission high-quality services with clarity about accountability;
- Meet the needs of more vulnerable groups;
- Obtain good quality intelligence about services and outcomes for monitoring purposes.

1. CONTEXT

In February 2013 the Leaders Committee at London Councils recognised the shortcomings of the Pan London HIV Prevention Programme (PLHPP) approach to HIV prevention. In response, Association of Directors of Public Health (ADPH) London, working with London Councils, designed the Future Commissioning of London HIV Prevention Services (FCLHPS) Project to oversee a London-wide needs assessment over the summer of 2013.

The FCLHPS project included six work streams:

- Epidemiological review
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The overall findings of the needs assessment are published in the report, "HIV Prevention Needs Assessment for London" (November 2013). This report is the output of one of the six underpinning work streams and focused on stakeholder engagement. ADPH London and London Councils will develop an options paper for a meeting of the leaders of the 33 councils in London, due to take place in November 2013.

Paul Fraser Associates were commissioned to undertake a stakeholder engagement process as part of the project management function for the needs assessment. The aim of the stakeholder engagement programme was to help inform the HIV prevention needs assessment by ensuring that stakeholders were informed about, and provided with, opportunities to engage with and contribute to the needs assessment.

2. INTRODUCTION

2.1 COMMISSIONING RESPONSIBILITIES

Since April 2013, local authorities have had the responsibility for their local public health provision and commissioning. This includes responsibility for the Public Health Outcomes Framework (PHOF), commissioning NHS Health Checks, smoking cessation, well-being, substance misuse, sexual health promotion and HIV prevention work. This includes sexual health service provision, primarily contraception and GUM (genito urinary medicine). They have taken on this critical role for local health improvement at a time of growing demand and diminishing resources.

In London the 33 London councils are now the commissioners for HIV prevention. Specific commissioning arrangements vary across the city, with some multi-borough arrangements, as well as individual borough commissioning, taking place. All have the same sexual health commissioning responsibilities, which are:

- HIV and sexual health promotion
- Open access Genito-urinary medicine (GUM)
- Contraceptive services for all ages

Stakeholders taking part in the needs assessment acknowledge that London councils now have to understand the complex and fragmented challenges posed by HIV prevention. They felt the need for cooperation and communication between all stakeholders, confident leadership, and excellent commissioning relationships in order to ensure seamless pathways between clinical and other support services for patients and service users.

2.2 HIV PREVENTION AND LOCAL GOVERNMENT

London Local Authorities account for 18 out of the 20 Local Authorities with the highest HIV prevalence in the country. (PHE Review of HIV epidemiology in London 2011 data; October 2013) The anticipated lifetime costs for treatment and care (including social care) of those living with HIV are extremely high. Primary and secondary HIV prevention work is considered to be a major priority for public health. In view of financial constraints, Local Authorities as the statutory bodies responsible for their localities will have inherent tensions as to what should be provided at borough or on a London wide basis. They will also need to consider a whole system management approach, which respects the sovereignty of each London council, and their individual population needs, without creating unreasonable inequalities of access and outcomes for HIV prevention.

London councils are in a strong position to exercise their roles and functions for sexual health, deliver improved outcomes for their residents, contain and reduce costs and work proactively with partners. Making the right decisions will be critical if the changes are to be supported by the many people they affect – local residents, service users, health and social care and other professionals alike.

The Equality Act 2010 states that public sector bodies: -

> "Must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage."

The overall HIV and sexual health budget is one of the largest budgets in the public health 'ring fence', and by law, sexual health clinical services must remain open access. Local Authority and Clinical Commissioning Group (CCG) commissioners will need to support service providers to deliver on tough operational challenges against the financial, strategic and policy backdrop, by applying robust leadership and management.

Local Authorities are under pressure to make substantial savings and the public health budget is now 'ring-fenced' until April 2016.

2.3 DEFINITION OF HIV PREVENTION

There is no consistent definition used for HIV prevention. In fact, one of the findings of this needs assessment was that considering HIV prevention alone is increasingly seen an outdated model, particularly in light of medical advances and increasing evidence of the impact of multiple risk taking behaviours and lifestyle choices on the HIV epidemic in London. The definition stated below emerged through consultation with stakeholders as part of the engagement process:

> "A collection of health promoting activities and interventions which aim to support and enable people to make informed choices, primarily aiming to reduce HIV transmission and new incidences, reduce HIV related health inequalities, and promote the health and well-being of those living with HIV"

Primary HIV prevention aims to support individuals to remain HIV negative. Secondary HIV prevention aims to ensure that those living with HIV remain well by supporting healthy lifestyle choices and encouraging adherence to treatment regimes for those on medication.

3. METHODOLOGY

Stakeholder engagement and/or participatory practice, is increasingly recognised as a key tool for implementing changes in service design and delivery, and is becoming a mainstream practice central to public policy making and service delivery.

Stakeholders for the FCLHPS needs assessment were identified as those with experience of providing HIV prevention services, those who are commissioning services, those involved in providing help and support to people living with HIV, professional bodies, and other relevant organisations such as the Department of Health and PHE. Stakeholder organisations to be involved were suggested by members of the project steering group. In addition, the project team used their extensive knowledge of the HIV sector in London to contact organisations to invite them to participate.

Stakeholders were contacted, initially by email, and invited to participate. A snowball effect was used to reach more widely, with stakeholders asked to cascade information about the engagement process through their networks. In addition HIV commissioners in London were asked to share information about the stakeholder engagement locally. The project team were able identify a broad range of stakeholders who were able to engage in the process.

At each stage of the stakeholder engagement process briefings were sent out to those stakeholders identified and also posted on the London Councils website. In addition, a feedback proforma was created and posted on the London Councils website, together with an email address to which stakeholders were able to submit responses. This proforma was also sent to all stakeholders identified before the deadline for responses to the Call for Evidence.

The following activities were undertaken to endeavour to gain views from the widest range of stakeholders feasible within the timeframe allocated:

- A series of one-to-one and small group stakeholder interviews
- A series of telephone stakeholder interviews
- An online questionnaire which was distributed across all London HIV commissioners
- Presentations to the London sexual health commissioners meeting and at the Safer Partnership evaluation report launch event
- A seminar organised by the South West London Network lead
- Use of the London Councils website and newsletter email list which encouraged wider participation and feedback
- A Call for Evidence
- A large scale stakeholder engagement event

This activity was all delivered between 17th June and 11th September 2013.

To help frame the wider engagement, meetings were sought early on in the process with strategic experts. This included those who had been involved in commissioning London wide, those involved in national HIV prevention programmes, and a selection of London based internationally recognised experts in public health and HIV prevention. The purpose of these meetings was to ensure that the project team was aware of any external factors, such as clinical and other developments, which may have had a bearing on HIV prevention in the future. It also helped them to understand the challenges of commissioning London wide and through national programmes and to help frame the

focus of the wider stakeholder engagement. In addition members of the Project Steering Group provided details of additional stakeholders they felt needed to be engaged.

The project team asked stakeholders clear, unambiguous questions about their views on what would make effective HIV prevention in London. The overall objectives of the stakeholder engagement process was to elicit those views, to record and collate suggested approaches for the future, and to provide a narrative to accompany the research and evidence review parts of the needs assessment. Stakeholders were asked to use their organisational role and experience to reply to the following:

- What are the key HIV prevention activities that in your experience are the most effective?
- What is your evidence of effectiveness?
- What are the key HIV prevention activities that should be done on a Pan London basis? Why?
- What are the key HIV prevention activities that should be funded at a local / cluster level? Why?

This stakeholder engagement process was not a linear progression of information, but a reflective view of experts with a collective vision adding value to the more evidence based approach. As the interviews progressed certain themes emerged and the input received at the stakeholder event confirmed these themes.

The stakeholder engagement process began in mid June 2013, with a briefing posted on the London Councils' website and distributed through the London DsPH network. Requests for interviews were then issued. Stakeholder interviews took place between 1st July and 4th September, and over 80 people took part. The Call for Evidence was issued on 16th July with a closing date for submissions of 9th August 2013.

The 11th September 2013 stakeholder engagement event was attended by over 120 people, a significant proportion of whom had not participated in any of the interviews. Places were limited to a maximum of two people per organisation to ensure fairer representation.

It was not an undirected approach and is reported as accurately as possible, on the broadest range of views with some structural conflict (inevitable), running alongside major organisational challenge.

Stakeholders' views are represented as accurately as possible, with the broadest range of views presented. The stakeholders themselves, with their range of styles, views, meanings and perceptions, were a powerful voice.

The advantages of holding this stakeholder engagement process for the development of future HIV prevention work were that it:

- Recognised the broad range of expertise available that already exists
- Strengthens the resolve to get things right
- Strengthens democracy by encouraging active involvement in decision making processes Will improve the quality and sustainability of new models as there is increased "ownership" of what needs to be decided, taken action upon and provided
- Provided the needs assessment team access to evidence that might be missed in published public health evidence reviews
- Builds more cohesion as new relationships are aligned using the opinions of those best informed, i.e. commissioners, clinicians, the service providers (third sector and statutory) and service users.

This stakeholder engagement programme has involved listening to a broad range of expert views and opinions, including:

- HIV commissioners
- HIV and sexual health clinicians and associated health professionals
- HIV prevention service providers
- Public health consultants and health promotion specialists
- HIV epidemiologists
- Academics and behavioural change specialists
- Community activists and patient representatives
- The faculty leads for British HIV Association (BHIVA), British Association of Sexual Health and HIV (BASHH), Medical Foundation for AIDS and Sexual Health (Medfash), National HIV Nurses Association (NHIVNA), Faculty of Sexual and Reproductive Health (FSRH)
- The London and England strategic leads for public health at Public Health England
- HIV Prevention England
- Department of Health

A full list of stakeholders who participated in the process can be found in Appendix A

3.1 LIMITATIONS

The delivery team endeavoured to identify and invite a broad range of stakeholders to engage with the needs assessment. However, the team acknowledges that some stakeholders may not have been able to participate due to the limited two-month time frame for delivery over the summer period. The stakeholder engagement programme was not intended to, nor pretends to be, a public health research project. The primary focus of this work was to provide useful narrative and expert opinion to the needs assessment.

4. FINDINGS

There were a number of themes that emerged from the stakeholder engagement process. The focus for the themes can be split into two areas:

- The what: the types of and approach to HIV prevention required
- The how: the commissioning, co-ordination and organisation required

There was consensus of opinion in many areas. However, there were also some key differences of opinion and these have been highlighted in this report. Many submissions from the Call for Evidence were provided by stakeholders and be found summarised in Appendix B

4.1 THE WHAT

4.1.1 THE APPROACH

"Are we waving or are we drowning?"

There are a number of key issues and suggested approaches to HIV prevention interventions:

KEY ISSUES

Stakeholders felt that many of the primary HIV prevention activities and initiatives currently funded require a more robust evidence base in order for commissioners to continue funding in the future. Communicating the evidence of effectiveness of HIV prevention was reported as a challenge. The solution would be to impose more appropriate and consistent monitoring.

Most stakeholders acknowledged that HIV testing is an effective primary clinical prevention initiative and that HIV treatment is an effective secondary clinical HIV prevention initiative; however, they cannot be delivered in isolation.

It was suggested that a combination approach to HIV prevention, rather than one universal approach, would not only show recognition that a range of factors can influence an individual's relationships and safer sex behaviour, but could also offer a menu of interventions with clear patient pathways and strong referral processes needed to meet the different need of individuals.

"One size definitely does not fit all! This is becoming a really big problem and we ignore it at our peril! We need to keep up with what's really going on out there. It will cost more than money if we don't – the human costs are too high to contemplate!"

Service user feedback was considered a useful element of measuring the effectiveness of interventions; however, it was felt that some commissioners place little value upon it.

"The time for TLC is over – we need to say it straight. Those people who are putting themselves or others at risk need to get help and we need to be offering it to them."

Stakeholders believed there was evidence to support the fact that interpersonal (face to face) interventions including counselling, use of Health Trainers and group interventions, help people make healthier life choices, including reducing risk taking behaviours. Interpersonal interventions were seen to acknowledge the complexities of individual lives which clinical/medical models and population based approaches do not.

"I have seen massive changes in people. I know that money is tight and that there is lots of noise around about our (counselling) work. What I would say though is the (financial) contribution made is pathetic compared to the lifetime costs of drugs for one person - they pay us less than those costs for a year's work and we manage lots of chaotic clients!"

The push to increase HIV testing as a prevention tool was seen by some stakeholders as potentially undermining the individual 'one to one' interventions. Some third sector organisations were concerned that there was little acknowledgement from some clinicians that behavioural interventions are effective, especially with gay men (positive and negative), and that the concentration on clinical interventions left little room for joint work. However, there was recognition from others that one to one interventions can add value to clinical interventions, especially when working with people with multiple risk factors and chaotic lifestyles, for example gay men with alcohol and substance misuse problems.

"We can't do randomised control trials every time we meet with people at risk. Is that what is now required to support the funding of this work? If so - we may as well pack up and go home as we can never tell if we have controlled a person's sexual behaviour - we just need to make sure they are equipped with the necessary information, and where to get help. Isn't that just good practice?"

Organisations reported using a range of assessment tools (including smartphone app tools) to identify levels of risk taking behaviours in order to be able to prioritise those at risk and then triage them to appropriate provision. This included counselling, working with Health Trainers, group work or other psychological services. These types of interventions were considered expensive and time consuming therefore they are targeted at those most at risk.

SUGGESTED APPROACHES

Stakeholders would like to see a consistency in the methodology used to evaluate the effectiveness of HIV prevention methods. Models offering a potential solution, for example the BASK (Behaviour, Attitudes, Skills and Knowledge), are currently used in some local and London wide HIV prevention work. It was thought that these need to be appropriately and consistently monitored before their use is agreed strategically.

It was, further thought that multi-disciplinary models of prevention and care, provided by well trained professionals, would support individuals with HIV prevention advice but would also provide support in a range of public health issues including alcohol, substance misuse, weight and smoking.

"They need to invest in interventions that will create sustained behavioural change. It's about winning over hearts and minds. What is going to create a culture of sustained change? To create a sustained solution is about engaging people meaningfully – email, follow-up, support groups, people who can lead service users through all the journey and point them to the right services - not just clinical interventions."

Stakeholders felt that widening the opportunities for service users to play an effective role in their own health management requires providers of services to engage and proactively listen. A model described as a 'warm referral' was suggested as a potential solution to the lost to follow-up; this is where the referrer makes the referral with the service user present, or if needed accompany them to the other service. Making this a stipulation on SLAs was seen as a solution; in addition 'warm referrals' are a more measurable outcome.

"A warm introduction is much better than just giving someone a phone number or address. People need to see the path for them - not just be left alone to find services."

4.1.2 DIVERSITY OF NEEDS

"Its gay men and many African communities who are most at risk and most likely to be HIV positive in London. Meeting their needs, or at least trying to, should be of the highest priority for Public Health and Local Authorities."

KEY ISSUES

Stakeholders believed assumptions on the homogeneity of gay men, men who have sex with men (MSM) and African communities were unhelpful, but there was consensus that interventions and activities specifically targeted should remain a priority for future commissioned prevention.

Migration into London poses particular challenges with stakeholders reporting new cohorts of gay men migrating from across the globe, and within African communities, new Francophone and Portuguese speaking communities. Many recent arrivals do not appear to be in touch with services and some are too nervous to come forward because of a range of other challenges happening within their individual lives such as finding work, housing and, for some, their immigration status.

For MSM, the move away from traditional venues (pubs/clubs) identifies a major cultural shift, and the ways in which gay men now actively seek sexual partners online challenges the old models of outreach. Gay venues are no longer the predominant way in which gay men socialise. Smartphone apps designed for men to meet for sex are increasingly popular, with MSM able organise and access sex in the borough they live with ease.

"Gay men require non-judgemental support - we have to make sure it's there."

An emerging trend raised by some stakeholder organisations, particularly clinical, HIV support and substance misuse services, was increasing numbers of MSM coming forward with substance misuse problems, particularly crystal methamphetamine (meth), mephedrone and GHB/GBL, primarily linked to sex and sex parties taking place across London. Some stakeholders felt that new innovative ways of undertaking HIV prevention need to be considered in addition to meet these new and challenging phenomena.

Although there were examples of excellent relationships with some gay businesses, major concerns were expressed about the lack of partnership approaches with some, especially those where 'sex on the premises' is happening with no accountability for robust HIV prevention messages and resources. The issue of drug fuelled sex parties for MSM, with little access to condoms, was raised several times as a major concern by both clinical and non-clinical stakeholder; however solutions to address this are in their infancy.

African communities were seen to be complex. Stakeholders reported marked differences in views, experiences and methods of communication, for example between first and second generation migrants and African people of different social classes. Stigma and discrimination affects many African communities, and fear of disclosure of HIV status is commonplace.

Many stakeholders believed the division between primary and secondary prevention work to be unhelpful: an example given was on presentations on HIV prevention provided to an African community or faith group which assumes the audience are all HIV negative. However, with 30% of new infections in London being in African people, it is likely many of the audience will be positive but undisclosed, so they miss out on getting vital sexual health and HIV information.

"Settings for work with African people is important – the church is a singular place you can engage a large audience at a single time. The role of faith leaders is crucial – people look up to them and this is a way to impact, but they have to be on board – and not all of them are."

It was felt that targeted work is required with 'very hidden populations'. These include discrete communities of, for example, African and other Black, Asian and minority ethnic (BAME) MSM who are married and would never identify as gay, sex workers, recent Eastern European migrants, some of whom are finding themselves in exploitative situations, either coerced into the sex industry, or at risk of abuse and violence.

"I wish people would stop talking about gay men and Africans as if they were just one sort of group with one set of needs. If only it was that easy! Not only that, it totally demeans the different cultures and experiences of the individuals who just so happen to be at higher risk because of all sorts of reasons"

SUGGESTED APPROACHES

"Invest in some good old sexual health promotion – invest in services, provide information for ALL people who need the services – the real thing is about keeping HIV prevalence low."

"The current methods favour the larger organisations who are not delivering and they are not picked up on it, whereas the smaller African and gay men's groups that are being innovative do not get funded. Why?"

Creating consistent support within local communities at risk of HIV is seen by the majority of stakeholders to be an important part of an effective HIV prevention programme. Given the chaotic or difficult challenges some gay men and African communities face on a day-to-day basis, this one to one and/or group support is seen to be highly valued.

Stakeholders welcomed more to be done in order to tackle 'head on' the issues of lack of disclosure, lack of consistent condom use and, for many women, domestic violence associated with HIV disclosure. Stigma and discrimination continues to play a major role in late diagnoses. For African communities, this may involve community and religious leaders in a robust evidence based approach to tackle these issues. A note of caution was expressed that the traditional approaches of outreach and work within faith and/or religious communities only reaches those who attend. Organisations working with African and other BAME communities particularly emphasised the need for a range of approaches due to the diversity of the populations with which they were working.

There were some stakeholders who believed that if one to one interventions were to be commissioned, then there needed to be increased transparency about how effective the interventions are, and a sense that individuals need to be encouraged and supported to embrace a "personal responsibility" to change their risk behaviours.

"There are core groups of people fuelling this HIV epidemic in London, and they need to be targeted! Not in 'blame' sort of way – but they definitely need some serious input!"

4.1.3 HIV TESTING AND TREATMENT AS PREVENTION

> "HIV testing should be seen as the pathway to support and prevention not an end in itself"

KEY ISSUES

The Public Health Outcomes Framework (PHOF) sets a clear direction for health protection. Reducing the number of late diagnosis of HIV is a key objective. London boroughs will need to examine their late diagnosis figures on a regular basis and ensure that targeted work is in line with their local epidemiology. Given the positive impact of early diagnoses on HIV related morbidity and onward transmission, there is consensus that HIV testing is an effective intervention to attempt to halt the progress of HIV. The arguments put forward were clear and unambiguous – that testing, and getting those who test HIV positive onto effective treatment, is an essential and evidence based HIV prevention intervention.

> "New medications – we never thought through the consequences of their arrival and impact. What does safer sex actually mean? Us providers and commissioners now have to work within the new landscape, and how can we effectively do that if it's all done locally – it doesn't make sense?"

There was a view from many stakeholders that access to HIV testing across the capital is patchy and inconsistent. This is despite London being an area of high HIV prevalence, and routine HIV testing in a wide range of settings (including primary care and in general hospital admissions) being recommended by BHIVA since 2008, (HIV testing guidelines 2008). Interestingly, there is little consensus on the clinical/medical model of HIV testing as a prevention tool alone. Some concerns were raised that seeing HIV testing as the means to an end is a limited intervention, without the back up of a behavioural change interventions to add value and support the individual.

Stakeholders were concerned at the perceived lack of HIV testing undertaken by London GPs, especially where patients are repeat attendees or show symptoms. Some expressed reservations on increasing GP involvement in HIV and sexual health, noting the massive increases in their workload and the fact that many had previous experience of GPs' reluctance to be involved in sexual health and HIV work.

Home sampling, where individuals can take an HIV test at home and send it off for analysis, is now available. This is a cost effective and confidential mechanism, and pilots have illustrated that it is popular. Home sampling ensures an individual with a positive result is linked straight into services.

Stakeholders were more concerned about the introduction of home testing kits where an individual can take the test and get the result at home with no links specifically into care and support services.

> "There are real problems with that – I mean; what if they have a mental health problem and the HIV + diagnoses is the last straw. How can that be a benefit and how are we to measure the prevalence if they remain anonymous and don't come forward for treatment?"

Many stakeholders commented that many HIV negative diagnoses were missed opportunities, suggesting that more attention needs to be given to health promotion

interventions and supporting individuals to remain negative. However, it was recognised that the role, skills and competencies of health advisors are variable, and many stakeholders identified the need to incorporate much broader risk factors into their intervention portfolio (including alcohol and drug use).

> "People are thinking about sex when they are going to have sex. They aren't thinking about HIV risk etc. they are thinking about sex! The current HIV prevention message is a clinical message – we are trying to change hearts and minds which is attitudinal. Targeting those at real risk is key."

The views expressed on Treatment as Prevention (TasP) as an HIV prevention tool were more consensual given the known benefits of early diagnoses and early treatment interventions. However, again, there was a note of caution – that too much focus on clinically based interventions does not address the individual health and other challenges faced by people with an HIV positive diagnoses.

> "HIV is much more than medication – stigma has a huge part to play. Treatment as Prevention (TasP) needs to go side by side with other programmes. We need to identify and discuss risk with people at different stages in their lives."

SUGGESTED APPROACHES

It was commonly agreed that as earlier diagnosis saves lives and reduces treatment costs, there is a need to increase the number of HIV tests in the community. Local Authorities now have the opportunity to introduce HIV testing in a broader range of community and primary care settings. Stakeholders believe there are opportunities to work in much closer partnership with third sector and other community services to provide Point of Care Testing (POCT) in a variety of settings.

Stakeholders recommended that all Local Authorities should be monitored on their numbers of local residents tested for HIV and be monitored on the numbers of residents diagnosed late for HIV, thus reducing the efficacy of their treatment and care.

Some stakeholders supported adoption of the "Halve It" Campaign, which is seen to be an effective medical intervention. (Halve the proportion of people diagnosed late with HIV (CD4 count <350mm3) by 2015 and halve the proportion of people living with undiagnosed HIV by 2015).

Given the emergence of new treatment technologies, including Post Exposure Prophylaxis (PEP) and Pre Exposure Prophylaxis (PrEP), most stakeholders expressed a desire that HIV treatment information be readily available for people living with HIV. A single source of treatment information, which works in close collaboration with clinicians and patients and service users, would be hugely beneficial in supporting those living with HIV to maintain their health and reduce onward transmission.

> "Treatment is good – but not as prevention. We need to change people's perceptions – attitudes and risks. For example we know many African people have low incomes – however they need healthy food to help them manage the toxins in the medications– people on low incomes cannot afford the right food. If they are negative, they need to be encouraged to remain so, and that means using condoms! Many African men won't use them so they put their women at risk. They need to be pointed in the right direction."

4.1.4 COMMUNICATION, INFORMATION AND RESOURCES

"We really need to consider carefully the impact of our condom distribution schemes and make sure that any mass media is targeted and accessible to all locally. Let's see those posters everywhere!"

KEY ISSUES

The availability of consistent quality information and resources is regarded as central to HIV prevention and there is an overwhelming sense that HIV prevention is failing to evolve at the same speed as societal changes and that embracing technology was far too slow and ad hoc.

MASS AND SOCIAL MEDIA

It was acknowledged that people like to access information about health and available services in an anonymous and confidential manner. Technology can facilitate this. However, without some form of co-ordination, the potential for duplication is great. The majority of stakeholders thought that there should be some strategic planning and development of mass and social media resources London wide.

There were different views expressed on the HIV Prevention England (HPE) mass media campaign. Some considered it relevant and valued; whereas others felt it was not branded in a way that speaks to the populations it needs to reach. HPE has been commissioned to compliment local provision. There was a view that, in the future, there needs to be more collaboration with stakeholders in London about the messages to be relayed.

There was consensus that all Local Authority public health messages need to be 'in that digital space'. The majority of stakeholders reported high level use of social media amongst both gay men and African communities although patterns of usage were different. Gay men tended to use smartphones apps and websites to meet other men, primarily for sex. African communities' usage was seen to be more varied, and includes general use of social sites and reading news from home countries.

There was no consensus on the effectiveness of mass HIV prevention media campaigns. The reach of campaigns was seen to be limited by the size of budget.

Views were expressed that advertising in the gay press was reaching smaller audiences, as smartphone applications take over. BAME MSM were reported to be using this technology too, as it enables them to access other men with more anonymity. Whilst there had been extensive promotion of HIV testing on some of the gay meet-up smartphone apps, there had been almost no reported prevention work, primarily due to the costs of advertising.

Some stakeholders felt that innovative HIV prevention ideas should be advertised through social media. However, there was a difference in opinion as to what was thought to work effectively. Some felt that factual information would have more of an impact on people, for example, increased information on the consequences of late diagnosis could prompt people to take action. Others felt it was more about directing people to services.

"It is a huge part of gay life. People still do go to bars and clubs – and will always do but the Internet is hitting whole groups of men who do not access the gay scene."

Some work undertaken by the National AIDS Trust indicated that the free media, such as the Metro and Evening Standard, as well as local press, is routinely read by African people and has a wider reach than African publications. Young people of African origin were reported to be using social media as a way of 'filling the gaps' in their knowledge of HIV and sexual health. The lack of universal PHSE within schools and the focus of any HIV prevention messages in faith settings having a focus on abstinence were cited as contributory factors to this lack of knowledge.

CONDOMS

At present there are a plethora of local free condom distribution schemes targeting different populations including gay men, African people and young people, as well as the Pan-London 'Freedoms' scheme (which distributes condoms to gay venues) and C-Card (condom card) scheme for young people. In addition, free condoms are available through GUM services, some GPs and some pharmacies.

There are a significant number of stakeholders who felt that messages about promoting condom use had faded and that there needed to be more high profile promotion of their use. This is particularly relevant in light of the evidence about HIV treatments reducing the infectivity of positive people.

Costs vary across London and there can be multiple schemes operating in the same borough, funded from different sources. Bulk centralised purchasing was seen as a way to keep costs down. At present some gay venues buy additional condoms from the Freedoms scheme. There was a view from many stakeholders that these venues should have access to condoms (and lubricant) included within any licensing agreements.

There was no consistency in monitoring uptake of condoms, with many schemes having no monitoring systems to identify who uses them. Some stakeholders were concerned that this could lead to the possibility that some people might abuse free condom availability. However, this is thought to be minimal.

Regardless of which methodology of provision was used there was consensus that access to condoms needed to be scaled up and consideration given as to how to link this into wider sexual health promotion messages around preventing STI transmission.

> "Let's face it - a condom costs very little, but for every time one is used we are potentially saving the lifetime HIV treatment costs for a person, then we really shouldn't have a choice. Scale it up!"

> "I know that some abuse the system and so having one central distribution point that is carefully managed on a pan-London basis would save a lot of money and could be evaluated effectively for each local borough. The local areas could then develop and monitor their own c-card schemes."

HEALTH EDUCATION AND HIV PREVENTION IN SCHOOLS (INCLUDING SRE)

The lack of consistent PHSE provision in schools was cited by almost all stakeholders as representing a major gap in health education. Many young people in London are learning about sex from the Internet and therefore there is no way to ensure that they are getting factual information. The need to educate young gay men about safer sex, in particular, was a concern expressed by stakeholders, considering the HIV prevalence rates in London.

Many stakeholders are frustrated by the lack of a co-ordinated response to HIV prevention, despite the evidence of effectiveness and need. 'Unprotected Nation', a report from Brook and FPA (published 2013), was cited by some stakeholders. It models how sexual health promotion and service cuts and restrictions will lead to a significant rise in STIs, HIV, and unintended pregnancies across all ages. In turn it results in a significant amount of human misery, and with the potential onward costs that will impact on local government services caused by increasing STIs HIV and teenage pregnancies. There was concern that this evidence would be ignored.

SUGGESTED APPROACHES

MASS AND SOCIAL MEDIA

Whilst stakeholders recognised that they could not make recommendations on any individual organisations they deemed suitable for funding allocations, there was a desire to influence the menu of interventions and activities required. In addition, many wanted to see an experienced web based provider able to 'upscale' population-based access to campaigns relevant to target groups. Information and advice on service provision needs to be targeted at everyone.

Pop ups on gay websites and increased use of apps for smartphones were highly recommended as a cost effective media campaign, and stakeholders suggested they would have far better impact. However, the cost of advertising would make it prohibitive for one borough to consider alone, so a joint approach was favoured.

There was a view that there could be a London-wide branded HIV prevention programme, with localised delivery, similar to the way in which the NHS Health Checks programme is delivered. NHS Health Checks, is commissioned by local government, but has national branding, key messages, delivery standards, and outcomes and is supported via a central website. A London wide HIV campaign would see all boroughs agreeing on the key messages to be delivered at the same time with the methodology for delivering the messages targeted to local needs.

CONDOMS

The availability of condoms and the promotion of their use was seen as an essential HIV prevention intervention. Better value for money could be achieved by using one centralised purchasing system for condoms, increasing all the councils' purchasing power.

It was felt that businesses (where sex on premises is known to occur) needed to make a bigger contribution with the provision of free condoms being made a requirement of their license agreements. The Freedoms shop should be publicised on all sexual health service and HIV prevention materials with the aim of making low cost condoms available to all resulting in decreasing pressure and reliance on free condom schemes. Also, some consideration should be given to developing a C-Card scheme for adults across London.

HEALTH EDUCATION AND HIV PREVENTION IN SCHOOLS (INCLUDING SRE)

Councils have an opportunity to ensure that their PHSE programmes inform and educate young people about good sexual health, to prepare them for life in a city with high HIV prevalence. In addition to provision in schools there is an opportunity through youth work informing particular provision for young gay men.

4.2. THE HOW

4.2.1 THE STRATEGIC DIRECTION AND LEADERSHIP

"These are exciting times - we could really get this right now, if there is the will and commitment! Very exciting!"

"How on earth are local authorities in London going to make sense of all this chaos, and filter all the crap so that we can get a proper coordinated commissioning approach for both pan-London and local work? It seems to be chaos and the numbers are going up? It needs to be sorted as a matter of urgency."

KEY ISSUES

Stakeholders agreed that the epidemiological evidence illustrates the need for a coordinated response driven by collaborative work as a matter of urgency. London was described as the "worst city in the developed world for the response to HIV prevention," with few strategic London-wide responses approached with London-wide ownership of the challenges. This is in stark contrast to other major cities where city-wide responses are in place to ensure a strategic and appropriate flexible response to HIV (e.g. New York, San Francisco, Washington DC).

Tensions are apparent between inner and outer London boroughs, and between high and low prevalence areas, with serious concerns expressed that localism and politics will impact on the future commissioning of HIV on a city-wide London basis. A real sense of "tinkering around the edges" was regularly expressed as a concern if commissioning was not appropriately coordinated.

Commissioning leadership has been really challenged as part of the re-organisation and transition. There was consensus that there needed to be clear demarcation of roles and responsibilities in future, but a fear that there will be confusion and chaos until it is more clearly understood and a coordinated response owned by all the commissioners. It was acknowledged, though, that the transition is recent and new relationships, roles and responsibilities will be developed and determined over the coming months/years. It was noted that some provider stakeholders had not fully understood the changes in commissioning and the move of public health from the NHS to Local Authority.

Fragmented HIV commissioning arrangements are now a reality, with commissioning sitting across local government and NHS England. London is disproportionately affected as it has 33 London boroughs, all with different HIV prevalence rates, diverse populations and no strategic coordinated commissioning capacity or leadership roles to ensure consistency or equity to HIV prevention interventions across the capital. Stakeholders' believed that an appropriate response to sector development would be dependent on Local Authorities' ability and willingness to collaborate on a London wide basis. Failure to do so will lead to further fragmentation, expensive duplication, and ineffective interventions.

"Not coordinating HIV prevention commissioning across London Boroughs is like giving providers a blank cheque book!"

Furthermore, with a move to more social enterprise involvement, and CCGs and other qualified providers waiting to join the new market opportunities, stakeholders felt that this would present challenges to both providers and commissioners. These emerging opportunities for new and alternative organisations are relatively immature at present, but for effective partnerships to work in the future, each needs to feel confident in their roles and understand their responsibilities in order to achieve the best possible outcome for patients.

The future role of the Health and Well Being Boards (HWBs) was unclear in relation to HIV prevention, and few stakeholders were able to tell the interviewers whether HIV was a priority on any HWB's agendas at present. Given they can determine priorities locally; concerns were expressed as to how they could jointly agree priorities for London if required, and there were concerns regarding their influence London wide.

Stakeholders were anxious that the 'Broader Determinants of Health' are still unhelpfully commissioned, with silos of commissioned activity, which does not reflect the individual's needs for support on the totality of their risky behaviour. For example drugs and alcohol play a major role in risk taking behaviour, including sexual activity, but the opportunities to work across departments and combining budgets is not facilitated or indeed encouraged.

There was confusion expressed as to the role of HIV Prevention England (HPE) in London, and lack of clarity on their role with Local Authorities in planning the work. About 39% of HPE spend is spent with specific benefit to London, there was a view that the Department of Health should allocate the funding according to the epidemiology and give a larger proportion to London.

Concerns were expressed as to how to better align clinical service provision with the HIV prevention agenda. Stakeholders widely recognised the role of GUM and community clinics in HIV prevention, and were keen to see this role enlarged. However capacity issues, lack of specific commissioned activity for prevention, funding pressures, training, skills and competencies were often cited as reasons why there was too little active and proactive HIV prevention work incorporated into GUM service specifications. Given that London councils are now responsible for commissioning GUM services, stakeholders saw this as a major opportunity to improve the role of GUM in HIV and STI prevention and to identify additional and alternative settings to increase uptake of HIV/STI testing.

Whilst NHS England is responsible for the treatment and care costs of people living with HIV, most stakeholders would support a case for the £110 million for GUM (which includes testing for HIV) to be maximised and encompass the breadth of interventions required to tackle the increasing numbers of people with HIV.

SUGGESTED APPROACHES

Leadership and sound reporting structures were seen to be key in supporting the strategic direction for the future.

There was overwhelming consensus from stakeholders that there needs to be a lead commissioning HIV and Sexual Health co-ordinator for London with formal delegated responsibility to support all 33 London councils. They would work closely with public health leads, policy organisations, third sector organisations, the London local area teams (LATs) at NHS England and service users, in order to develop a robust, strategic, evidence based commissioning plan for London.

In addition, it was proposed that there be three cluster network coordinators (comparable with LAT boundaries) that can support their local government colleagues leading on sexual health and HIV in each borough, with specific support for discrete and appropriate commissioning plans applicable to each borough's differing needs.

This structure would:

- Provide a city-wide approach in line with other European and USA cities which makes economic and strategic sense for boroughs, multi-borough and London wide
- Reduce duplication of services and support value for money
- Ensure adequate provision to meet the challenges of rising incidence and prevalence of HIV locally and across London
- Identify economies of scale
- Be responsible for strategic commissioning and develop contracts, service level agreements (SLAs) and procurement for service delivery and resources
- Target the work at the relevant risk populations
- Be responsible for SLA development with the third sector and in partnership with contract managers for clinical services
- Monitor and evaluate the services to ensure that the activities and interventions are having the right impact at the borough levels
- Ensure that service user voices are incorporated into the monitoring and evaluation of service delivery
- Ensure local activity and interventions at borough level could be commissioned dependent on discrete needs, with cluster/network coordinators ensuring that responses are not duplicated on ad hoc basis and that there is strategic commissioning at every level

In addition:

- There could be a clear role for PHE in supporting London DsPH and commissioners to identify the main evidence base for outputs and positive outcomes, with local health intelligence supporting the case for the overall commissioning intentions
- It is proposed that the role of GUM services in the overall HIV prevention agenda should be reviewed in light of the current HIV services review in London, and the interface between these reviews made explicit and transparent with a clear outcome communicated to all stakeholders

4.2.2 COMMISSIONING AND CONTRACTING

"Creating unhealthy competition may be good for commissioners but it's no good for public health"

"We have a very real opportunity now to improve all this - to really pull together and make sense of what needs to happen across London, in clusters and locally. I just hope there is the political will to do just that?"

KEY ISSUES

COMMISSIONING EXPERIENCE

The commissioning of HIV prevention was perceived by some stakeholders to be contentious, and concerns were raised as to the variance in commissioning expertise, and how individual Local Authorities see the priority. There was an overall sense that commissioning responsibilities had yet to "bed down and really take hold in their new home of local authorities".

The shift to ever-smaller areas had not been seen to support London wide initiatives and the necessary innovation and creativeness required to deliver HIV prevention models appropriate to Londoners' needs.

There was some concern expressed that there was little incentive for Local Authorities to prioritise HIV prevention as they will not be responsible for the lifetime drug costs for those living with HIV, as HIV treatment and care costs lie with NHS England.

There was also a sense that present commissioners were "too reliant on the perceived wisdom of current providers", and that this needs to be addressed to reassure providers that there will be strong accountability for decision making and governance arrangements.

Stakeholders agreed that commissioners should be clearly defining their expectations, defining excellence and settling the parameters for the providers. This will rely on excellent communication channels.

Stakeholders called for an iterative commissioning process to be introduced for London with major opportunities to commission appropriately across the broad range of public health interventions, tailored to support individuals with their lifestyle challenges and choices - including and not exclusively for HIV.

SERVICE LEVEL AGREEMENTS (SLAS),CONTRACTS AND TENDERING

"Can we stop the tail wagging the dog please?"

Comments on the present situation regarding SLAs raised a number of issues for stakeholders. These concerns included the following:

- Present SLAs are not deemed to be flexible enough.
- Some provider stakeholders are concerned that forced levels of delivery promises set within SLAs often persuade commissioners to fund the 'bigger players', and invite bids on discrete areas with no capacity to develop joint work or to encourage partnership approaches.
- Competitive funding/bidding arrangements are viewed as problematic as partnerships with and between providers are 'set up to fail' as a result of the bidding/tendering process. It is widely acknowledged that there has been more success recently with HPE, but the DH and not Local Authorities fund this.
- There was a plea from stakeholders that all Local Authorities examine carefully the local contracts they have with smaller organisations and ensure that any specifically targeted work is well co-ordinated with that of the bigger players.

- The competitive tendering financial arrangements are not seen to be conducive to nurturing broader partnership approaches and relationships, so the importance and value of interventions are not being enabled in a progressive, co-operative and beneficial manner.

Questions were asked on how decisions regarding future SLAs and tenders would be agreed. Specifically, stakeholders asked:

- How will the policy for competitive tendering be managed so that it is seen as an open, transparent and fair process, opening the way for collaborative bids?
- How and what mechanisms will be used to interrogate decisions to go out to tender?
- How will local councils behave if they do not agree with the possibility of some London wide approaches to HIV prevention?

Stakeholders also suggested that future SLAs and Service Specifications should be used to improve practice in a number of ways. Suggestions included:

- Innovation and flexibility to be encouraged within SLAs.
- Due diligence be applied to robust Service Specifications with clear procedures for monitoring and evaluation.
- HIV treatment and care services to be far better aligned with the HIV prevention agenda, with Service Specifications encouraging collaboration between all health care providers within the NHS, and third sector based partners.
- Clear SLAs could be used to monitor and evaluate the purpose, outputs and outcomes of a range of interventions, which encompass identified cultural norms, and challenge perceived wisdoms.
- SLAs could have an element of evaluation development as well as a standard evaluation framework.

COMMISSIONING TO MAKE THE MOST OF PATHWAYS

> "It's not enough just to bung a lone drugs worker into a clinic. That's just lazy commissioning. You need a collaborative approach with a very clear pathway in to effective services that meet those distinct needs"

Stakeholders suggested a more formal pathway into and out of clinical services with increased structural rigor and critical thinking. It was felt that SLAs should specify that clinical providers engage with third sector providers, and include joint working and accessible and seamless referral pathways. In particular, stakeholders would like to see:

- The development of rigorous care pathways into alcohol and drug services to create an interlinked matrix of support, ensuring that sexual history taking includes alcohol, drug & vulnerability issues which is crucial to focus on minimising all risks, not merely sexual risks.
- The use of the major opportunities available now for sexual health and HIV clinics to actively embrace the broader public health agenda and support those coming to their services to seek help.

- Skills and competencies training made available for all clinic staff that wish to 'skill up' and offer more individual tailored support. This is seen as a priority as it could target those known to be at risk, vulnerable or those who report behaviour, which puts them and others at risk. (It was noted that within the clinics there is no specific tariff for this specialised intervention. Given that to be beneficial, sessions should be a minimum of 30 – 40 minutes, the impact on a clinic, which actively seeks to minimise harm for both, its HIV positive and negative patients can be significant).
- Third sector organisations with the necessary skills to be commissioned to support clinics and encourage robust referral pathways. Some third sector organisations felt 'pushed out' by some GUM clinics especially where health advisor roles are deemed to be doing the broader support role. Given the increased recognition that a 'combination prevention' approach is the way forward, there were also concerns raised that there are too few health adviser roles in clinics, and that access to more specialised psychology or psychiatry services may be more appropriate but there is limited access for sexual health HIV patients and service users.
- HIV testing of new registrants in primary care, with HIV testing being part of routine practice. Stakeholders welcome the broader implementation of peer led sexual health Sexual Health in Practice (SHIP) training across London to increase capacity skills and competence within primary care, in particular GPs in high prevalence areas. The (SHIP) scheme is a hugely successful training and educational programme, developed in Birmingham and successfully piloted in north London, and welcomed as an innovative and meaningful way in which to engage GPs at local level.
- A defined or ideal configuration of targeted HIV prevention service models and activity agreed
- Partner notification and contact tracing to be explicitly commissioned as part of a GUM service with monitored data on numbers and evidence of attendance and treatment uptake.

"These are not LOCAL services – they are about communicable disease control for all. They shouldn't be used as a pawn in a political boundaries game. They are open access, and with that goes confusion for those who keep wanting to talk about localism!"

VFM AND FUNDING

What is seen as value for money (VfM) was reported as being inconsistent by stakeholders; with concerns about the level of understanding of how an investment in HIV prevention now may not yield a return for many years to come. There were very serious concerns expressed as to how Local Authorities would collaborate effectively in such a contentious area as HIV, both due to the population groups it effects and the fact the majority of transmission occurs through sex, which is not a topic many people are comfortable talking about within a politically charged environment.

Stakeholders felt that the high cost of late diagnosis of HIV treatment and subsequent social care costs should encourage Local Authorities to form alliances in order to concentrate on effective commissioning for HIV Prevention.

Some felt that rather than asking "what can HIV prevention funding do to meet the diverse health needs of those at risk of HIV exposure?' the question might be turned around to ask 'what can HIV prevention funding do to realign other services so they better meet the diverse health needs of those at risk of HIV exposure?"

There was universal consensus on the need for an integrated tariff, especially now that there are major opportunities to address HIV and sexual health at one clinical intervention point. This would help local councils know they were paying like for like and therefore getting VfM.

There was some concern over previous decisions made in relation to commissioning, for example, some stakeholders believed that the funding and contract rollovers for the previous pan-London work ended up made the programme less effective and cohesive than it could have been, some expressed doubts as to the impact of much of that work.

> "We would be going back to the Dark Ages if we have 33 London Boroughs tinkering around the edges with silly pots of money which will have no or little impact. The investment is paltry compared to the lifetime treatment costs of one person living with HIV. Please - let's get this right"

4.2.1 DATA MANAGEMENT, MONITORING AND EVALUATION

> "What happened to all that monitoring we did for the last report? Where did it go? Who used it and for what purpose?"

KEY ISSUES

The value of any funded intervention needs to be made explicit; with measured outputs reflecting clearly defined outcomes. However, four issues emerged from the stakeholders where data management was an issue.

LACK OF STANDARDISED MONITORING AND EVALUATION FRAMEWORK

> "Poor monitoring processes lead to poor fractured responses and bad behaviours. This must be addressed with good commissioning leadership and accountability, with providers making their data accurate and accessible."

Stakeholders were aware that some providers had developed their own monitoring and evaluation tools, that could give bias to reports. Stakeholders expressed strong views that service user voices should be included in any monitored data and that there was a sense that this has been previously ignored as part of any overall evaluation process. Whilst some expressed concerns that service users would be biased anyway, as they were using specific services, this should not exclude their right to have their say in what is being delivered.

Whilst there was broad recognition that the transition of responsibilities to Local Authorities is recent, most were hopeful that the use of data would be made explicit within the next round of decision making on allocations.

LACK OF TRANSPARENCY RE PURPOSE AND WHAT HAPPENS TO THE DATA

There was a perception amongst most stakeholder providers that monitoring and evaluation data had been ignored by commissioners and that it was less than helpful in identifying priorities for commissioning intentions and in supporting the worth of commissioned activities. Commissioners also reported this as a problem. This lack of transparency has posed problems for this project as some previous actions have resulted in mistrust among stakeholders.

Stakeholders were concerned that so called "lack of evidence of effectiveness" was being used as a reason not to invest, and that the monitored data from individual organisations had been either ignored or marginalised in a bid to cut costs. However, the key point that Stakeholders raised is that the necessary resources are not in place to sustain HIV prevention interventions on a population level.

DATA COLLECTION BURDEN DISPROPORTIONATE TO THE INVESTMENT

Effective monitoring and evaluation takes time and resources. It was reported that funding for information technology and the relevant personnel to properly manage the process had not been incorporated into SLAs. There was a sense among stakeholders that the bigger organisations could absorb the data collection burden into management costs; something that smaller organisations would struggle to do. There was also a concern expressed by some commissioner stakeholders that without some form of joint commissioning arrangement some providers may charge multiple boroughs for the same set up and management costs.

INSUFFICIENT PROVIDER RESOURCES TO MONITOR AND EVALUATE EFFECTIVELY

There were concerns as to the skills and competencies of organisations to properly monitor and evaluate their work.

"They (commissioners) assume we all know what it means and how to do it. I know it's not rocket science but we could do with some training and clear levels of accountability for all this data collection. I mean - will it be used to support us or is it a bit of a double-edged sword? Is there a standard one so we are all measured equally? I don't think so."

SUGGESTED APPROACHES

There was consensus that a standardised approach to monitoring and evaluation of services in any future commissioned HIV prevention work would be welcomed. Stakeholders felt that this could be developed in partnership between public health and providers, linked to HIV surveillance programmes and using nationally recognised expertise at PHE. There was recognition that a standardised tool was not applicable to every aspect of delivery but that any local borough variations could be accounted for in the SLAs. A sexual health balanced scorecard could be introduced as a standardised tool with local metrics to account for variations.

There was also a clear message from stakeholders that the data collated should be used to inform any future commissioning intentions, and that a transparent process would be welcomed in order to allow for flexibility and programme development on a borough, multi-borough and London wide basis.

It was felt that service user voices should be actively encouraged as part of the data collection process, and providers need to foster a culture, which encourages and enables those voices to contribute and be heard. This is in line with the recommendations of the post-Francis report, with more feedback mechanisms for service providers to listen better and act accordingly. Consistent mechanisms for reporting, learning and sharing information from service users were suggested within SLAs, linking services and creating pathways. This would allow information and evidence of effectiveness to be co- ordinated at a service and programme level.

> "Recommendation - 'introduce a balanced scorecard approach and support providers to use it'"

4.2.4 RELATIONSHIPS AND BUILDING PARTNERSHIPS

> "It would be great to be able to work together, do joint bids and genuinely avoid duplicating stuff out there"

KEY ISSUES

There are real differences between partnership working and collaboration. Stakeholders felt that, in order for partners to work together effectively across their organisational boundaries, they need to genuinely respect and value one another's roles, responsibilities and agreed and expected outcomes.

The new commissioning partners across health and local government, and the provider organisations, will all now have fundamentally different roles from those previously held. Stakeholders believed that commissioners needed to be stating the "what" and providers the "how", which is why clinical leadership and engagement is deemed so important.

There was a sense that expectations were shifting and yet communication of those expectations is not being effectively disseminated. Providers in particular, feel vulnerable.

> "We've got a chance now - really recognise that money is tight and get together to review where we are. Working together might mean some things go to the wall, but if there is some clever strategic commissioning, I think we will understand it all better"

There were some excellent examples of London wide relationships cited by stakeholders; notably the GMI partnership that offered a range of interventions to the most vulnerable populations at risk of HIV (notably gay men and some African MSM communities). However, there was also a sense that there is some duplication amongst providers and that this is not necessarily cost effective.

Some clinical services expressed a loss of confidence in third sector organisations, although others expressed a real willingness to engage and develop the relationships. There was little consensus on this but a clear recognition that things were changing and that partnerships, mergers and collaborative work between clinical services and third sector providers was the way forward.

SUGGESTED APPROACHES

There was consensus that there needed to be a focus on the relationships between all providers in order to enhance the visibility of effective interventions that can be procured on a local or London-wide basis.

There was a perceived need to capitalise on the relationship with the clinical services, resulting in more robust pathways for patients and service users, and improved partnership work with third sector organisations.

There was a view that wider recognition that a 'combination prevention' approach will be more effective in the longer term, enhance partnership work and value the different contributions made to support the individuals in their health challenges.

There needs to be far greater partnership work developed to address the complexity of drug and alcohol use amongst gay men.

> "We need to inspire gay men to develop ideas – commissioners can help them do this – rather than just creating a specification and going for tender."

4.3.5 A FUTURE APPROACH

> "HIV prevention is an out-dated model. We cannot look at this in isolation from all the other public health priorities and the broader determinants of people's health! It surely must now be called "risk prevention?"

There was general agreement amongst stakeholders that the HIV prevention services currently provided are based on historical models, partially dating back to pre-HIV treatment days. There was enthusiasm for a more holistic approach to public health interventions, which need to encompass a broader range of health determinants, including substance misuse, smoking cessation and alcohol use.

In terms of the future model, many stakeholders cited the Marmot enquiry into health inequalities stating that it gave a much broader and more relevant context to risk. The majority of stakeholders were clear that there were missed opportunities by having such a narrow definition of HIV prevention for people's health seeking behaviour.

Acknowledging Marmot, there was much discussion about the broader determinants, which impact on people's health, and the fact that a discrete funding model actually: "Misses the point of supporting effective health seeking behaviour". 'Making it Count' (a gay men's HIV prevention Framework) and 'Knowledge the Will the Power' (an African HIV prevention framework), were cited as previous HIV prevention models that should not be lost and should be built upon in the future.

Stakeholders saw narrow definitions as responsible for stopping collaborative partnerships and introducing elements of competition and hierarchy into service provision. Creating unhelpful silos with discrete funding streams offered little opportunity for proactive and innovative risk prevention strategies to be developed and financially supported.

> "Can public health support themselves and us and please implement Marmot...it'll really help us look at the individuals in the context of their lives"

Given the known epidemiological evidence on the disproportionate numbers of gay men, MSM, and African communities infected and affected by HIV, there was general consensus that the health inequalities debate needs to be applied more rigorously and proactively to the future commissioning intentions.

HIV prevention literature offers many theories and techniques on behaviour change but, so far, there has been little research on the effectiveness of behaviour change techniques and interventions across a range of different communities and at risk populations.

Most stakeholders were clear in their support for a rich and robust London wide and community based intervention model, which meets the broad range of needs of service users, patients and other clients. The model should aim to reduce the stigma and discrimination and health inequalities often associated with living with HIV.

In determining what is now required for future HIV prevention commissioning in London, stakeholders suggested revisiting the menu of interventions, and the financial allocations. Stakeholders see a need to use broader London wide risk prevention strategies that take advantage of economies of scale and directly acknowledge the broader determinants of health in individual's lives. This must include information and targeted support on substance misuse, smoking and alcohol.

> "Every issue around sexual health, HIV and all the other public health challenges that we have should be treated equally, as they all impact on one another"

In summary, there was broad consensus that an effective model for the future commissioning of HIV prevention should be inclusive of all risk factors relevant to the individual, and that the activities and interventions for the future models of service delivery must encompass that breadth and range.

5. SUMMARY OF CONCLUSIONS

There are challenges ahead for HIV prevention- both in terms of evidence of effectiveness and appropriate targeting. Against a backdrop of diminishing public sector funding, increasing HIV prevalence and new incidence, Local Authorities will need to "up the ante" re HIV prevention.

Stakeholders believe that political will is required to ensure that this work is neither undermined nor under resourced.

This stakeholder engagement process has identified numerous variables that will impact on the effectiveness of HIV prevention strategies in the future.

This stakeholder engagement process has identified a number of key issues and suggested approaches that are discussed in detail in each section of the report.

Stakeholders proposed three clear areas of need that should be incorporated into any future model of London HIV prevention work. These were as follows:

- Both local and London wide approaches should be underpinned by a clear commissioning strategy that acknowledges the variations across boroughs. This could include some cluster arrangements.
- Centralised condom procurement for locally determined distribution (including C- Card schemes)
- Recognition and use of new technologies to communicate HIV prevention messages with a co- ordinated and consistent approach to the development of online social media and mass media

Public Health England (PHE, DH 2013) has agreed to provide specific support to commissioners of HIV and sexual health services. This includes:

- Provision of evidence-based advice on how to improve HIV and sexual health services
- Practical help in local areas to
    - Embed activity designed to reduce health inequalities
    - Develop plans to monitor outcomes and assess quality assurance
    - Improve the capacity and capability of the HIV and sexual workforce
- Facilitation of collaborative commissioning in local areas by helping to set up professional networks
- Development of commissioning tools such as service specifications and standard contracts
- Provision of costing and other tools to help to provide effective and cost efficient services and interventions
- Commissioning of national level social marketing and behaviour change campaigns in order to link locally provided behaviour change work on improving sexual health with the broader national level work

DsPH are now bedding in to their new arrangements within Local Authorities and, as such, will be drawing on the skills and competencies within PHE to assist in their new roles within local government.

The future commissioning for HIV prevention now lies with Local Authorities; this provides new opportunities and ways of working. Public Health will now need to make some strategic decisions based on these reports to support those commissioning decisions.

APPENDIX A:

STAKEHOLDER ENGAGEMENT - LIST OF PARTICIPANTS

African Advocacy Foundation: Agnes Baziwe, CEO & Dennis Onyango, Community Development Co-ordinator

African Health Policy Network: – Francis Kaikumba CEO & Jacqui Stevenson, Head of Policy

Antidote: David Stuart, Education & Training Manager

British Association for Sexual Health and HIV: Dr Janet Wilson, President

Black Health Agency: – Jabu Chwaula, Programme Manager – HIV Prevention England

British HIV Association: Dr David Asboe, Chair

Chelsea & Westminster Foundation NHS Trust: Dr Simon Barton, Clinical Director &– Dr Alan McOwan, Consultant Code Clinic 56 Dean Street

Central North West London NHS Foundation Trust: Robert Goodwin, Manager HIV and Sexual Health & Dr Karim Dar, Clinical Director

City University London: Professor Jonathan Elford, School of Health Sciences

Department of Health: Kay Orton, Lead, HIV and STIs Policy and Programmes – Sexual Health Team & Baroness Gould, Chair of Sexual Health Forum

Ergo Limited: Mark Wrapley and Peter Scott, Directors

Ethnic Health Foundation: Godswill Udo, CEO

Freedoms: Tanya Percy, Service Manager

Faculty of Sexual & Reproductive Healthcare: Dr Chris Wilkinson, President

GMFA: Matthew Hodson, Chief Exec

London Borough of Bexley: Robbie Currie, Sexual Health Commissioner

London Borough of Croydon: – Lea Siba, Health Improvement Principal – Sexual Health

London Borough of Hackney: Adrian Kelly, Senior Strategist – Sexual Health

London Borough of Haringey: Susan Otiti, Assistant Director of Public Health

London Borough of Havering: Elaine Greenway, Acting Associate Director, Public Health

London Borough of Hounslow: Niki Lang, Acting DPH & Siju Raphael, Sexual Health Commissioner

London Borough of Lambeth: Rebecca Adejao Sexual Health Commissioning Lead on behalf of **Lambeth Southwark and Lewisham** Paul Steinberg Commissioner LSL (Pan London HIV Prevention)

London Borough of Newham: Michelle Howells, Commissioner Public Health

London Borough of Tower Hamlets: Chris Lovitt Associate Director of Public Health & Will Nutland, Public Health

MBARC: Michael Bell, CEO, Stephen Bitti-Alcon, Head of Sexual Health Programmes & Patrick Dollard, Wellbeing & Communities Manager

MEDFASH: Dr Ruth Lowbury, Chief Executive

Metro:

-Dr Greg Ussher, Deputy CEO Metro

- David Naylor Director, Partnerships and Collaborations

- Tony Furlong, GMI Mentor Supervisor & Rob Wardle GMI Service Manager

- Edith Ntabyera, **Harbour Trust** Service Manager, - Andrew Evans, Director Health and Community Services and Anders Neilson, Gay Men's Health Promotion Officer

NAM: Caspar Thompson, Chief Exec & Keith Alcorn, Senior Editor

NAT: Deborah Jack, CEO & Dr Yusef Azad, Director of Policy and Campaigns

Naz Project London: Marion Wadibia, CEO, Parminder Sekhon, Deputy CEO, Ivana Paccoud, Research and Policy & Wondwosssen Eshetu, Head of Programmes

North East London Sexual Health Network: Teresa Battison, Network Co-ordinator

NHS England (London): Jess Peck Service Specialist – Blood and Cancer (London Region) & Hong Tan, London team health and justice lead commissioner

PACE: Kath Blake, Manager Counselling and Groups & Nuno Nodin, Project Coordinator

Positive East: Mark Santos, Director & Steve Worrall, Deputy Director

Public Health England: Professor Kevin Fenton, National Director, Health and Wellbeing & Professor Jane Anderson, Sexual Health and HIV, Health and Wellbeing Directorate

Public Health England: Health Protection Services: Dr Anthony Nardonne Epidemiologist, Dr Valerie Delpech Consultant Epidemiologist & Dr Alison Brown, Principal HIV Scientist

Public Health England: London: Yvonne Doyle, London Regional Director

Royal College of Nursing: Colin Roberts, Fellow in Sexual Health & Advanced Nurse Practitioner Chelsea and Westminster

Royal Borough of Greenwich: David Pinson, Health Improvement Principal

Royal Borough of Kingston: Peter Taylor, Commissioning Lead, Sexual & Reproductive Health

Sex Education Forum: Cllr Jonathan McShane

Sigma Research, London School of Hygiene & Tropical: Ford Hickson, Senior Researcher

South East London Sexual Network: Gary Alessio, Co-ordinator

South West London Sexual Health Network: Janine Railton, Co-ordinator

Three Flying Piglets: Patriic Gayle & Simon Sheriff

THT: Paul Ward, Acting CEO, Guy Slade – Parliamentary Officer, Dominic Edwardes – Marketing Director, Hannah Drinkwater – Fizza Qureshi London Operations Managers

THT HPE: Ben McClelland Policy officer & Carey James – Head of Programmes

Tuke Institute: Dr Rupert Whittaker

WLGMP: Karen Skipper – Director & Dee Wang – Data and Research Lead

Westminster City Council, Royal Borough of Kensington and Chelsea, London Borough of Hammersmith and Fulham: Ewan Jenkins, Sexual Health Commissioner

SWAGNET WORKSHOP ATTENDEES

African Cultural Promotions: Gertrude Othieno & Danmore Sithole

Africans Getting Involved: Peter Onwu

Croydon University Hospital: Claire Phoenix, Health Advisor & Dr Ali Elgalib Consultant

London Borough of Croydon Public Health: Fred Semugera & Sharon Boakye

London Borough of Sutton and Merton: Clare Philp & Kate Milstead

London Borough of Wandsworth: Gosaye Fida

Sutton & Merton Community Services: Hilda Dewa, HIV CNS

Metro / First Point: Charlie Parker

St George's Hospital: Health Adviser – Courtyard Clinic Bernard Kelly & Mariam Tarik

St Helier Hospital Medical GU: Health Adviser – Malachy Otlagan

SHAKA: Robert Adams, Constantia Pennie, Jaque Otieno

South London HIV Consortium / SWL: Amira Gorani

South London African Women Organisation (SLAWO): Charles Kyazze

Kingston Hospital Wolverton Centre: HIV CNS Anne Murphy-Spence

Stakeholder event attendees (not list previously)

Isoken	Aiyanyo Aigbekaen	Sexual health lead	Brent Council
Mesfin	Ali	Health Services Manager	Embrace UIK Community Support Centre
Elijah	Amooti	Founding Director	The African Eye
Allan	Anderson	Chief Executive	Positively UK
Ian	Archer-Wright	Project Officer	South London HIV Partnership
John	Ashley		West London Alliance
Helena	Ball	Senior Account Manager	Resonant Media
Dr Alasdair	Bamford	NIHR Research Training Fellow	Imperial College School of Medicine at St Mary's and CHIVA
Somen	Banerjee	Director of Public Health	Tower Hamlets Council
Julie	Billett	Director of Public Health	Camden and Islington Council
Martha	Bisirikirwa	Project Co-ordinator	ACP
Sarah	Blair	Programme Manager Planning & Performance	London Borough of Barking and Dagenham
Kath	Blake	Counselling & Groups Manager	PACE
Sima	Chaudhury	HIV Commissioning Manager	South London HIV Partnership
Deryck	Brown	Research and Policy Officer	AHPN
Mba	Chujor	Health Protection Officer	Havering Council, Public Health Dept
Elizabeth	Clowes	Assistant Director Commissioning	London Borough of Lambeth
Emma	Corker	Teenage Pregnancy Co-ordinator	Southwark Council
Helen	Corkin	Public Health Commissioning Manager	London Borough of Waltham Forest
Addicus	Cort	Principal Policy and Project Officer	London Councils
Rosanna	Cowan	Public Health Commissioner	Harrow Council
Paul	Crook	Consultant Epidemiologist	Public Health England
Monica	Desai	Specialist Registrar	Public Health England
Richard	Desmond	Trustee	London Lesbian & Gay Switchboard
Hilda	Dewa	Clinical Nurse Specialist HIV/AIDS	NHS Sutton and Merton Community Services - Royal Marsden NHS Foundation Trust
Rageshri	Dhairyawan	Consultant in Sexual Health and HIV	Barking, Havering and Redbridge Hospitals University Trust
Patricia	Durr	Head of Policy, Communications & Fundraising	METRO
Yaccub	Enum	Head of Public Health Partnerships	London Borough of Waltham Forest
Babs	Evans	Head of Wellbeing & Communities	MBARC
Kate	Ezeoke-Griffiths	Senior Public Health Specialist	London Borough of Redbridge
Kathryn	Forbes	Head of Public Health Engagement and Impact	Body & Soul

Pastor	Fred	CEO	
Michelle	Howells	Sexual Health Commissioning Manager	
Pat	Howley	Assistant Director Contracts (Sexual Health)	
Ian	Howley	Editor - FS magazine	
Ruth	Hutt	Consultant in Public health	
Monica	Imbert	Health Improvement Advanced Practitioner	
Foizal	Islam	Commissioning Lead Sexual Health, HIV and LTC	
Sviatlana	Istamianok	Interim Health Trainer Manager	
Zainab	Jalil	Public Health Commissioning Officer	
Yudaya	Kakembo	Patient rep	
Joy	Kyeyune	Public Health Officer	
Nicola	Lang	Senior Public Health Commissioner, Sexual Health	
Deirdre	Love	Senior Sexual Health Promotion Specialist	
Siobhan	Lynch	HIV Nurse Specialist	
Will	Maimaris	Specialist Registrar in Public Health	
Wendy	Majewska	Clinical Services Manager	
Michael	Mancinelli	HIV Prevention Services Coordinator	
Heather	McMullen	Researcher	QMUL
Dr Esse	Menson	Consultant	Evelina Children's Hospital, Guy's & St Thomas' NHS Foundation Trust - CHIVA
Simon	Mercer	Assistant Commissioner	NHS England
James	Miller	Director	Living Well cic
Monty	Moncrieff	Chief Executive	London Friend
Mimi	Morris-Cotterill	Interim Programme Director (Sexual Health)	London Borough of Bromley
Joanna	Moss	Wellbeing & Communities Programme Officer	MBARC
Clement	Musonda	CEO	The Rain Trust
Ian	Nichol	Public Health Programme Manager	West London Alliance
Ernest	Nkrumah	Executive Director	The Ernest Foundation
Nuno	Nodin		PACE
Jennifer	Nsubuga	Co-ordinator	African Health Forum
Amanda	O'Donovan	Consultant Clinical Psychologist	British Psychology Society

Lugard	Ohen	Service/ Clinical Lead	Guy's & ST Thomas' Community Health Services, NHS Trust
Tom	Ojwang		Opportunity for All
Dr Toyin	Oremakinde	Consultant in Public Health Medicine	Public Health England
Chloe	Orkin	Lead for HIV and HIV/Hepatitis C Research	Barts Health NHS Trust
Nancy	Padwick	Commissioning Manager	London Borough of Islington /Islington CCG
Roger	Pebody	Editor	NAM
Mark	Platt	Lead Writer/ Researcher	Three Flying Piglets | 3FP.CO.UK
Steve	Powell	Category Manager	London Borough of Hillingdon
Elaine	Rashbrook	Public Health Consultant	Public Health England
Dr Iain	Reeves	Consultant GU Medicine	Homerton Hospital
Mikaela	Smit	Researcher	Matrix
John	Stewart		Department of Health
David	Stuart	Outreach & Education Manager	London Friend
Sarah	Sturrock	Interim Strategic Lead, Health & Adult Services	London Councils
Roy	Trevelion	BHIVA HIV Guidelines Patient Rep	
Michael	Underwood	Nurse Practitioner	56 Dean Street, Chelsea & Westminster Hospitals
Margaret	Unwin	CEO	PACE
Toj	Wang		Opportunity for All
Peter	Weatherburn	Senior Lecturer, Sexual Health & HIV	London School of Hygiene & Tropical Medicine

APPENDIX B:

CALL FOR EVIDENCE SUBMISSIONS

Submissions containing over-arching or strategic perspectives

Nineteen submissions focused on strategic priorities or overarching considerations with regard to commissioning HIV preventative services in London. Fourteen were from organisations and five were from private individuals. Common elements ran throughout the submissions and these are abstracted and presented here.

INTEGRATED AND STRATEGIC COMMISSIONING

The strongest theme to emerge from these submissions is that the commissioning of London's HIV prevention services should be integrated and strategic rather than piecemeal.

Submissions pointed out that the HIV epidemic in London is driven by a range of factors that are interrelated in complex ways. These include structural factors (social inequality and deprivation, inequality between genders), social factors (for example homophobia, racism, stigma and discrimination, community norms that support or undermine protective behaviours, lack of knowledge or information etc.), interpersonal factors (for example psychological morbidities) etc. Commissioning of HIV prevention services should seek to address all of these factors in a strategic and intelligent way. Moreover, the provision and promotion of clinical services is only one (albeit important) element in addressing the epidemic.

INTEGRATION OF APPROACHES

The different approaches identified (clinical approaches, interpersonal approaches, community approaches, mass-media, condom distribution) should not be seen as competing or mutually exclusive, but should be interdependent and mutually reinforcing. Moreover, no one approach is likely to be sufficient in isolation to reduce HIV transmission. Therefore, clinical approaches (for example, testing and treatment, secondary prevention) cannot be effective without community approaches that target those for testing, remove the barriers to testing and support those in treatment. The interdependence of such approaches is illustrated well in a submission by NAM: an info graphic showing the 'treatment cascade' and the submission from the Tuke Institute. [NOTE – Neither are available for inclusion as appendices or referencing in draft report as they are paper submissions, but have been requested in electronic format for subsequent versions]

However, the aim of community approaches should not be solely to increase access to clinical services but also, to address the factors contributing to HIV exposure and transmission. The latter cannot be addressed by clinical services.

The range of approaches available to reduce HIV transmission might therefore be articulated under a strategic plan that states overarching aims, for example facilitating access to clinical interventions and addressing the factors that drive HIV exposure and transmission. The plan might also specify the role of each approach in meeting these aims and how these approaches should work together.

WITH AND BY COMMUNITIES

Another common theme was that HIV prevention should be carried out with the consent of the communities involved. That is, community interventions need to emanate from communities; be owned by communities and not focused on communities by others.

LONDON-WIDE AND BOROUGH COMMISSIONED SERVICES

A further strong theme to emerge was that both London-wide and borough level commissioning were appropriate and could be considered to have complementary roles. Some suggestions were made regarding the complementary role of each level of commissioning.

- Strategic development could be carried out on a London-wide level taking into account the specificity of the epidemic in various regions and boroughs. This might include setting strategic aims and methods as well as commissioning/specifying integrated monitoring and evaluation provision.
- There may be opportunities to specify a range of approaches on a London-wide level, but for these approaches to be applied differently in different areas/boroughs to meet/reflect specific needs, populations or target groups. For example, one-to-one interventions in community settings (like outreach or health trainers) may share a common aim, but the venues visited will depend on local epidemiology, socialising patterns and need as will the approach taken in these venues.

Several submissions advised against boroughs acting entirely in isolation around HIV prevention stressing that there should be a clear rationale for carrying out prevention on a local level and that local work should reflect overarching London-wide approaches and goals.

Finally, one of the priorities for London-wide/borough level commissioning is to make referral pathways between services as clear, direct and secure as possible.

GRANULARITY

Related to the previous theme is the theme of granularity, that is, that London can be seen as a whole or a collection of various communities and populations and responses need to take account of the many facets of the city.

London can be seen in terms of its position as a capital city and a global city attracting visitors and migrants from all over the country and internationally. This will have a major impact on epidemiology (in terms of sexual mixing patterns etc.) as well as the burden of HIV on the city. These considerations would need to be incorporated into any HIV prevention plan.

There is a need for general population campaigns targeted at all Londoners that seeks to change attitudes towards HIV, normalise HIV testing and seek to integrate those living with HIV into the life of the city, that is, reduce stigma associated with HIV.

Within the overall population of Londoners most at risk for HIV (MSM and African communities), specific sub-groups are at greater risk for a range of factors. In strategic planning, there is a need to consider whole population approaches alongside more intensive approaches for these sub-groups.

The different populations affected most by HIV (MSM and African communities) are concentrated, in terms of residence, in different localities. However, their social networks and social activities are diffuse. Certain boroughs contain centres for social and recreational activities that are used disproportionately by different groups (for example MSM commercial scene use). Therefore, boroughs may differ markedly in their prevention activities but all local activities might reflect on how they contribute or relate to prevention across London.

Opportunities for boroughs to integrate HIV prevention into policy and services

In addition to actively commissioning HIV prevention, boroughs are responsible for many aspects of the environment that influence the HIV epidemic. These include:

- Environmental Health and Trading Standards Departments in relation to licensing and HIV prevention with businesses serving /targeting communities.
- Drug Action Teams in relation to drug use of local MSM populations.
- Education in relation to improving knowledge and understanding of risks in relation to sex and drug use.
- Housing and Social Care services in relation to reducing vulnerability to HIV among homeless people and young people in care and in receipt of social services. Moreover, improved social care for people with HIV will have an impact on secondary prevention.

There are therefore substantial opportunities for boroughs to address some of the main 'upstream drivers' of the epidemic.

RISES IN INCIDENCE

Finally, there were strong concerns across some submissions regarding recent rises in HIV infections in London, specifically amongst MSM. Two interpretations regarding what factors may be driving these rises were offered.

The first referred to reported changes in recreational drug use amongst MSM. Evidence to support these reports come from observed changes in the profile of attenders to community sector treatment setting and reports of GUM and HIV clinical providers at certain clinics in central London. These refer to reported rises in use of specific recreational drugs (Crystal methamphetamine, Gamma butyrolactone and Gamma hydroxybutyrate) which may be ingested, snorted or injected in the context of sex and social activities that leads to larger numbers of sexual partners, greater sexual mixing, less protected sexual activities and the disinhibiting of personal and/or communal safer sex norms.

Responses include making clearer and more appropriate drug treatment and support pathways for MSM. However, others also pointed out the need for greater engagement with businesses and services targeting at risk groups operating within the private sector. The main instances given are businesses that facilitate increased sexual exchange either in physical or virtual space, and businesses that advertise or promote these services. Such services and businesses may contribute to HIV by providing access to or normalisation of risk behaviours and the advertising of the same. These services could be better regulated and their contribution to HIV prevention increased.

The second interpretation pointed to studies showing correlations between the spend on HIV prevention and changes in HIV incidence pointing out declines in the spend on HV prevention with at risk communities in London over the last 10 years and concluding that this may also be a contributing factor in the rise in incidence.

SUMMARY

1. OVERARCHING SUBMISSIONS

Nineteen submissions focused on strategic priorities or overarching considerations with regard to commissioning HIV preventative services in London.

- The strongest theme to emerge from these submissions is that the commissioning of London's HIV prevention services should be integrated and strategic.
- Different HIV prevention approaches should not be seen as competing or mutually exclusive, but should be interdependent and mutually reinforcing. Moreover, no one approach is likely to be sufficient in isolation to reduce HIV transmission.
- The aim of community approaches should not be solely to increase access to clinical services but also, to address the factors contributing to HIV exposure and transmission.
- The range of approaches available to reduce HIV transmission might therefore be articulated under a strategic plan that states overarching aims roles etc.
- HIV prevention should be carried out with the consent and ownership of the communities involved.
- Both London-wide and borough level commissioning are appropriate and could be considered to have complementary roles. Some suggestions were made regarding the different roles of each level of commissioning.
- Several submissions warned against boroughs acting entirely in isolation around HIV prevention stressing that there should be a clear rationale for carrying out prevention on a local level and that local work should reflect overarching London-wide approaches and goals.
- London's role as a global city attracting visitors and migrants will have a major impact on epidemiology and HIV burden of HIV. These considerations would need to be incorporated into any HIV prevention plan.
- There is a need for HIV prevention at several different levels: general population, HIV risk groups and sub-populations within risk groups.
- There are opportunities for boroughs to integrate HIV prevention into pre-existing policy and services. Examples cited included Environmental Health and Trading Standards Departments, Drug Action Teams, Education, Housing and Social Care. Interventions in these areas would address some of the 'upstream drivers' of the epidemic.

There were strong concerns from some submissions regarding recent rises in HIV infections in London amongst MSM. Two interpretations regarding what factors may be driving these rises were offered. The first concerns the rise of recreational drug use within the context of sex. The second relates to the decreasing spend on HIV prevention over the last number of years.

APPENDIX C:

VALUES AND PRINCIPLES FOR COMMISSIONING HIV PREVENTION IN LONDON

a) Service user involvement and participation in HIV prevention services commissioned:

With service users being encouraged to actively participate in the planning, delivery, monitoring and evaluation of services, and to provide forums for regular feedbtack to commissioners and providers.

b) Empowerment:

Welcoming service users to make choices about the services they use, and to provide them with the knowledge and information required to increase their resilience and self-esteem, and support them in making healthy lifestyle choices.

c) Equity:

Of access and provision, appropriate to service user needs and which takes into account their race, gender, sexuality, religious and cultural beliefs. Recognition of particular influences on the individual and the interplay of those factors, which will impact on their sexual health.

d) Accessibility:

With services being clearly advertised and signposted, and clear clinical and other pathways defined and understood by all health and other professionals working with SU's and patients, so that services are accessible for all who need to use them.

e) High Quality Provision:

The aim of the government's QIPP (Quality, Innovation, Productivity and Prevention) is a large-scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It aims to improve the quality of care the NHS delivers while making up to £20billion of efficiency savings nationally by 2014-15, which will be reinvested in frontline care. Local authorities could adopt the process and monitor all HIV prevention work against this process.

f) Effectiveness:

Services should provide evidence of their effectiveness in relation to the Public Health Outcomes Framework (PHOF) and to patient experience. Use of local data and data management will be a crucial part of this process.

g) Positive Images of Provision

All HIV prevention programmes should encourage positive and affirming views about what they provide and how they treat their patients and service users. Given the stigma and discrimination experienced by many during this process, this should be encouraged as a priority value.

The principles that LA commissioners may adopt, and which underlie those values could include:

a) Providing a clear sense of direction to the services, setting out explicitly what their expectations are against future service level agreements

b) Supporting providers and service users to work together to agree the way forward within the current circumstances

c) Acknowledge, head on, the changing environment, with all the competing demands and pressures, and find ways to address them and provide an evidence base for future commissioning intentions

d) Agree measurable outputs and outcomes for the PHOF and the broader sexual health provision as agreed by the professional bodies

e) Allocate the funding within a jointly agreed evidence based framework which encompasses both local and London wide provision.

APPENDIX D:

SUMMARY OF SUGGESTED APPROACHES

There needs to be a strategic framework, jointly developed and adopted by all London boroughs, and specifying the level at which interventions and activities are commissioned. This could include borough, multi-borough and London wide work identified as a priority for each council. A strategic approach to future commissioning would address areas of duplication.

WITHIN THE FRAMEWORK THE FOLLOWING IS PROPOSED:

Appointment of a London commissioning HIV and sexual health co-ordinator role with formal delegated responsibility to support all 33 London boroughs, working closely with public health leads, third sector, NHS services, LATS at NHS England and with service users.

Identify 3 cluster network coordinators (comparable with LAT boundaries) who can support their Borough colleagues leading on sexual health and HIV in each Borough. This ensures strategic commissioning at all levels and reduces duplication.

Identify a clear role for Public Health England to support DsPHs and commissioners in identifying the main evidence base for outputs and positive outcomes, with local health intelligence supporting the case for the overall commissioning intentions.

Commission multiple structured interventions at sexual health and HIV clinics and increase the training in theory and practice of behaviour interventions for all professionals. This multi-disciplinary model of prevention and care will support the individual in a range of public health issues including alcohol, substance misuse, weight and smoking.

Identify a clear role for GUM services and incorporate HIV prevention into their SLAs. GUM clinics need to ensure that skills and competencies training is available to 'up skill' those who could and want to offer more individual tailored support. VCO's with those skills could be commissioned to support clinics and encourage robust referral pathways in a more consistent and seamless pan-London basis.

Target one to one interventions carefully at those most at risk, and develop robust pathways with clinics to ensure "warm" introductions so that those most in need of tailored and individual support are supported to seek the interventions required, and don't 'get lost'.

Introduce the integrated tariff, especially now that there are major opportunities to address HIV and sexual health at one clinical intervention point.

Wide dissemination of condoms is crucial as an effective intervention. A condom scheme could be subsidised and rolled out on a London-wide basis.

Widen the C-Card scheme to all London Boroughs and increase the age range.

Local authorities to work with smaller organisations to develop SLAs with robust outcomes and so increase their capacity and capabilities.

Local contracts should incorporate capacity building in order to support local organisations to address the issues with their discrete 'at risk' communities.

London Boroughs need to examine their late diagnosis figures on a regular basis and ensure that targeted work is in line with their local epidemiology.

Local authorities should be monitored on their numbers of their local residents tested for HIV and on the numbers of residents diagnosed late for HIV.

Increase the number of HIV tests in the community to reduce undiagnosed prevalence and prevent further transmission of HIV. Earlier diagnosis saves lives and reduces treatment costs.

POCT should be available in a range of community and other settings.

Partner Notification and contact tracing should explicitly be commissioned as part of a GUM service with monitored data on numbers and evidence of attendance and treatment uptake.

Primary care teams need to be encouraged to normalise HIV testing in routine practice.

Implement SHIP training across London to increase capacity skills and competence within primary care, in particular GPs in high prevalence areas as a priority.

HIV treatment information should be readily available for people living with HIV as there are major benefits which maximises the efficacy of treatments, contributes to adherence, and supports the longer term retention in care pathways to clinical and other services.

Public health and LAT's should monitor the local Boroughs HIV drugs expenditure to ensure that any HIV prevention programme is supporting local residents.

Stakeholders suggest increased resources to 'highly visual social marketing' interventions, web based campaigns relevant to target groups, and increased use of apps for smart phones.

Develop a pan-London standardised approach to monitoring and evaluation services in partnership between public health and providers.

Service user voices should be actively encouraged as part of the data collection.

APPENDIX E:

SUPPORTING GUIDANCE FOR LOCALAUTHORITIES

A number of published documents were cited by some stakeholders. These can support local authorities with their sexual health promotion and HIV prevention commissioning:

FRAMEWORK FOR SEXUAL HEALTH IMPROVEMENT IN ENGLAND

A framework for sexual health improvement in England' (DH, 2013), provides a framework and guide for those responsible for planning and commissioning services, and for those who provide them.

The framework suggests 5 objectives for local service delivery to ensure that good outcomes are maintained and improved. All 5 objectives will impact on HIV prevention and they are

- Access to accurate, high-quality and timely information that helps people to make informed decisions about their relationships, sex and sexual health;
- Preventative interventions that build personal resilience and self-esteem and promotes healthy choices;
- Rapid access to confidential, open access integrated sexual health services in a range of settings, accessible at convenient times;
- Early accurate and effective diagnoses and treatment of STIs including HIV, combined with the notification of partners who may be at risk;
- Joined up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings.

https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

COMMISSIONING SEXUAL HEALTH SERVICES AND INTERVENTIONS: BEST PRACTICE FOR LOCAL AUTHORITIES

This guidance is designed to help local authorities to commission high quality sexual health services for their local area as part of their wider public health responsibilities, with costs met from their allocated public health grant. It provides:

- Guidance on the legal requirements to provide comprehensive, open access sexual health services for contraception and testing and treatment of sexually transmitted infections
- Best practice, and references to a number of other resources which local authorities may find useful

https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

THE PUBLIC HEALTH OUTCOMES FRAMEWORK

The sexual health public health outcomes were established for local government in 2012 and are included in the Public Health Outcomes Framework (PHOF) for 2013–16. They are as follows:

- A continuing fall in the rate of births to women under the age of 18
- A reduction in the proportion of people with HIV whose infection is diagnosed late
- An increase in chlamydia diagnoses among young people aged 15–24, to be achieved through screening

https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

LOCAL AUTHORITIES (PUBLIC HEALTH FUNCTIONS AND ENTRY TO PREMISES BY LOCAL HEALTH WATCH REPRESENTATIVES) REGULATIONS 2013

This provides details of the requirements need to have in place for the provision of certain services, including:

- Open access sexual health services for everyone present in their area, covering free HIV and STI testing and treatment
- Notification of sexual partners of infected persons
- Free contraception, and reasonable access to all methods of contraception

It does not set out how the services should be provided, nor do they impose any requirements on the numbers of services, locations, opening times, type of service model, waiting times or staffing levels. This will be determined locally and will make a difference to the quality of services and the achievement of the Public Health Outcomes Framework (PHOF).

Patients attending from out of area are able to access services wherever they are, but the LA's will need to arrange out of area payments for GUM services, which are consistent with confidentiality requirements and an agreed tariff price.

HIV screening will be the responsibility of the local councils although treatment and care costs will be the responsibility of the specialist commissioners in London's Local Area Teams, NHS England.

http://www.legislation.gov.uk/uksi/2013/351/regulation/6/made

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