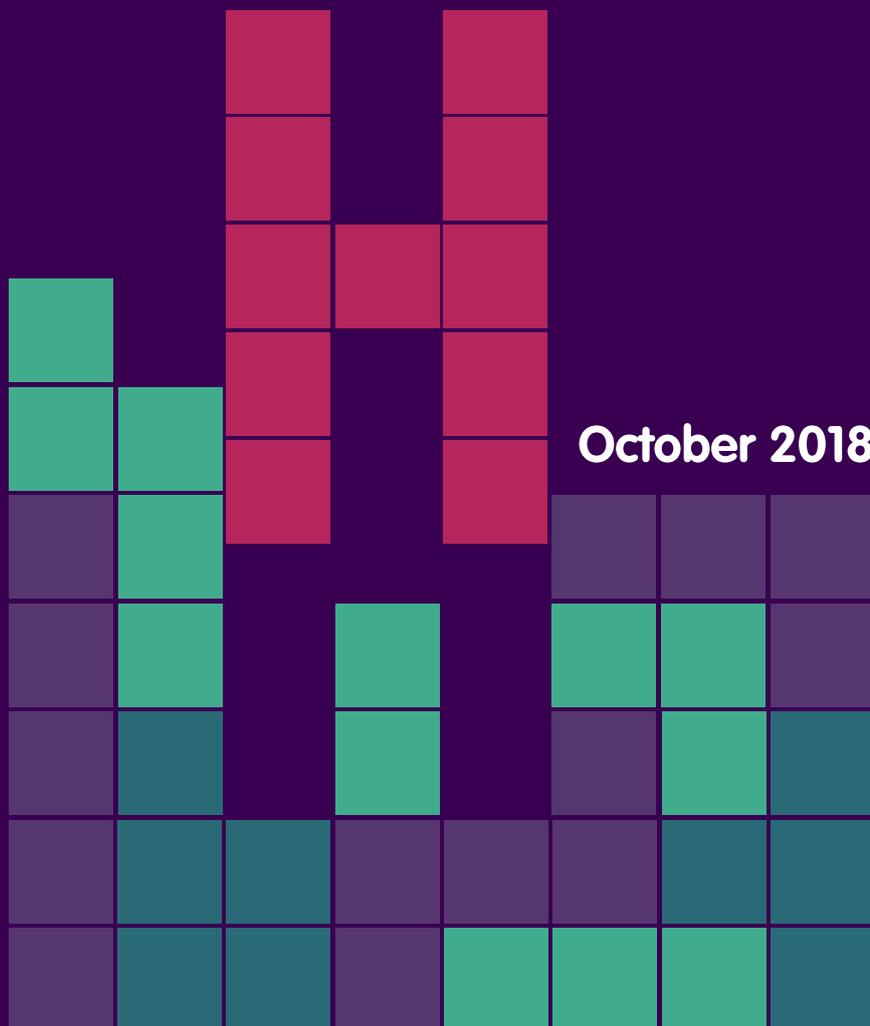




HIV and Integrated Care

– can STPs deliver?

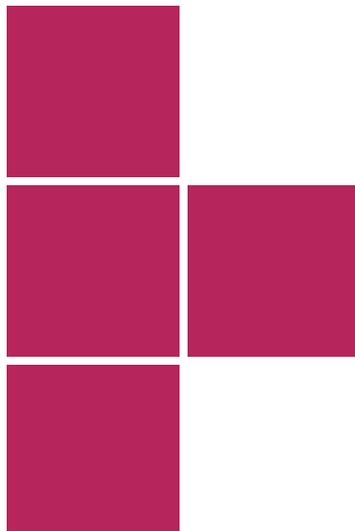
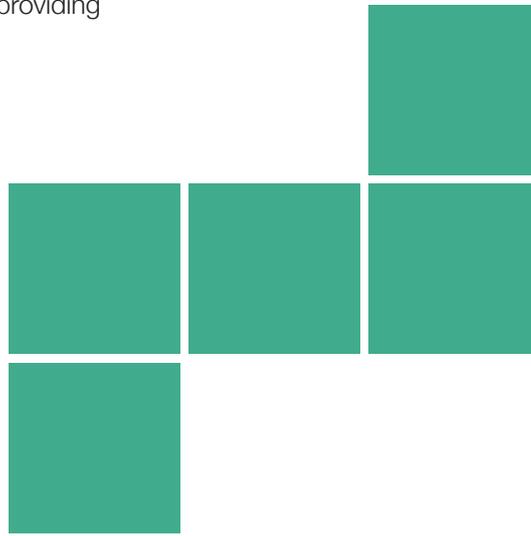


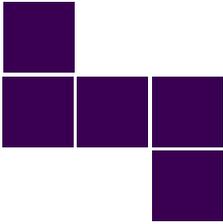
TRANSFORMING
THE UK'S
RESPONSE
TO HIV



ACKNOWLEDGMENTS

We are grateful to all commissioners, Directors of Public Health, clinicians, voluntary sector organisations and STP leaders who provided information on what is happening in relation to HIV within their STP area. Thanks to Alex Baylis, Assistant Director, Policy, at the King's Fund, for his comments on an early draft of this briefing paper. We would also thank Gilead and Janssen for providing funding to support this project.





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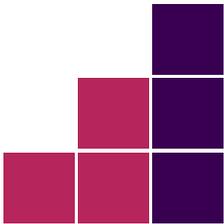
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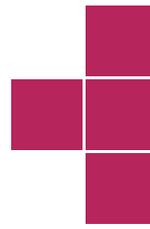
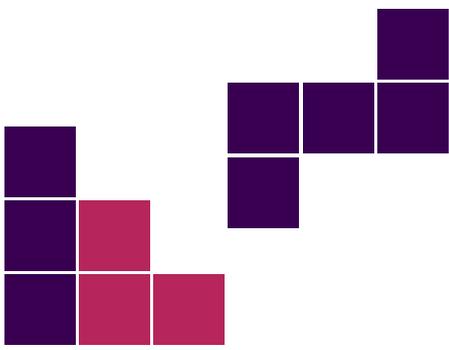
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EXECUTIVE SUMMARY

BACKGROUND

People living with or at risk of HIV in England are particularly affected by a fragmented health and care system, involving multiple commissioners and providers, who are failing currently to plan and deliver services in an integrated way.

This lack of integration means, despite continuing high rates of late HIV diagnosis, that key healthcare settings are failing to test for HIV. This lack of integration also means, with an ageing population of people with HIV and high rates of co-morbidity, that too often there is a lack of joined-up support from primary care, social care, mental health services, other hospital services, and from services which assist with long-term condition management.

NHS England is now prioritising improved integration of care. To that end NHS England has established 44 Sustainability and Transformation Partnerships (STPs). STPs work on a larger geographical footprint than local authorities and Clinical Commissioning Groups (CCGs), bringing commissioners and providers within the health and care system together to plan in a coordinated way around the needs of the local population and the individual patient. A few areas are evolving further into Integrated Care Systems (ICSs). NAT undertook a brief survey of STPs which had mentioned HIV in their STP plans in order to find out what potential STPs might have to improve the integration of HIV services.

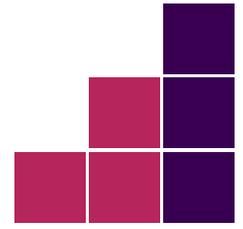
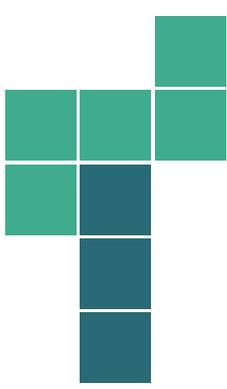
FINDINGS

A relatively small number of STPs (seven) mentioned HIV in their STP plans, plus Greater Manchester Health and Social Care Partnership (an ICS) in its Population Health Plan. Of the 23 STP areas that included a unitary or upper tier local authority with high prevalence of HIV, only six mentioned HIV in their plans. It is good to see mention of HIV in all but one of the London STPs and also in the ICS process in Greater Manchester. Overall, however, STPs failed to focus appropriately on HIV as they began their work and drafted their plans.

Where HIV was mentioned in STP plans, it was a result of pre-existing collaboration amongst local HIV stakeholders, local champions with the vision and persistence to make it happen, and some traction with more generic issues already on the STP's commissioning agenda (for example, around prevention).

With the exception of Greater Manchester, there has been almost no STP engagement specifically with people living with HIV and with local HIV clinicians and stakeholders, either during the development of the STP plans or since. Given how disproportionately affected people living with HIV are by service fragmentation and health inequalities, STPs need to do more to find out what their needs are and what they think should be done to meet those needs.

As STPs have matured, there is some evidence in the STP areas we examined of increasing collaboration around HIV amongst commissioners and providers across local authority and CCG boundaries, although it is often less clear whether the STP was formally involved. Such collaboration



THERE HAS BEEN ALMOST NO STP ENGAGEMENT SPECIFICALLY WITH PEOPLE LIVING WITH HIV AND WITH LOCAL HIV CLINICIANS AND STAKEHOLDERS.

there is significant variation currently in both the extent and content of HIV-related activity. A more consistent response by STPs to their local HIV epidemic is required, and processes put in place so that they can communicate and learn effectively from each other.

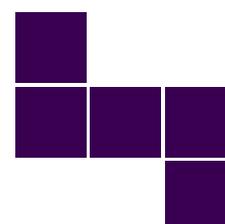
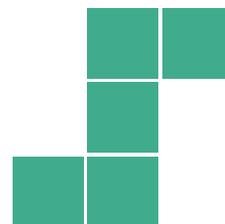
STPs will not in and of themselves fix the current fragmentation in HIV care. They at best provide a framework within which the responsible bodies (NHS England, CCGs, local authorities, Public Health England and local providers) can improve integration. Recent activity in some of the STPs we looked at does suggest they can make a difference. Key to STP action is local HIV stakeholders taking the initiative in collaboration, identification of need and development of proposals for STP consideration. We would encourage colleagues across the HIV sector to take advantage of the opportunities presented by STPs to improve integration of care.

is welcome and is an essential first step for any STP-level activity.

In Greater Manchester and London there is some valuable work to improve HIV testing across the health and care system. We hope STPs and ICSs can engage NHS England, CCGs and local authorities to implement HIV testing in hospitals (outside the sexual health clinic) and GP settings in line with NICE public health guidance.

There has been little work within the STPs to improve long-term condition management of people living with HIV. More recent attention to this urgent issue in North Central London and South East London STPs is encouraging. However, much more work needs to be done in STPs across the country to address the complex long-term condition needs of people living with HIV.

Even amongst those STPs of similar HIV prevalence which mentioned HIV in their plans



INTRODUCTION

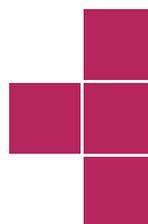
The NHS Five Year Forward View set out as a priority improving the integration of healthcare around the needs of the individual.¹ The Health and Social Care Act 2012 had further fragmented the healthcare system in England – the NHS Five Year Forward View aimed to begin the process of putting things back together.² HIV care is particularly affected by such fragmentation and NAT published a report in December 2016, ‘HIV in the Future NHS’, which looked at NHS England integration proposals and their potential to improve outcomes for people living with HIV.³

HIV has historically been addressed somewhat differently from most other conditions within the NHS (for example, HIV outpatient care is open access without the need for GP referral; HIV drugs do not go through NICE technology appraisals; HIV is commissioned via NHS England Specialised Commissioning). There have been good reasons for such an approach, but the downside has been the relative neglect of HIV within wider NHS policy development, such as that around long-term conditions. NAT is committed to ensuring that current proposals for change and improvement within the NHS take full account of the needs of people living with HIV.

Building on ‘HIV in the future NHS’, we look in this briefing paper in more detail at one important NHS England initiative, the development of Sustainability and Transformation Partnerships (STPs). We look at the potential of STPs to support better integration of HIV services, taking as case studies those STP plans which make explicit mention of HIV. In this briefing paper we describe what we did and what we found and make recommendations as to how we can maximise the potential of STPs to benefit people living with HIV and their experience of care.



**EFFECTIVE HEALTHCARE
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HEALTHCARE SYSTEM.**



BACKGROUND

WHY INTEGRATION MATTERS

Effective healthcare must begin with the interconnected needs of the individual patient (whole person care) rather than with the convenience of the separate elements of the healthcare system. It has to be integrated and joined up. Integration needs to go beyond healthcare itself and also encompass social care and other services essential to wellbeing.

It is, therefore, frustrating that coinciding with a focus on integrated care with the healthcare system has been a further fragmentation of commissioning structures for HIV (and indeed for health more generally) as a result of the Health and Social Care Act 2012.⁴ This fragmentation has been the subject of extended commentary, for example by NAT,⁵ by the APPG on HIV and AIDS,⁶ and the King's Fund.⁷

The King's Fund report identifies, for example, poor coordination between HIV clinics and GPs, a lack of coordinated planning with mental health and drugs and alcohol services, as well as with social care (which needs to be far better prepared for an ageing population of people living with HIV). HIV is marginalised from wider discussions in the NHS on long-term condition management. In many places HIV and sexual health services are becoming unmoored from each other as they are commissioned by different bodies, despite substantial cross-over in expert staff and populations at risk. Experience of people living with HIV of non-HIV specialist clinical settings was mixed, with delayed referral and stigma often being a problem.

This fragmentation is rooted in fractured commissioning responsibilities. NHS England treats HIV but does not have the prime

responsibility for its prevention and diagnosis (which fall in the main, though not exclusively, to local authorities). Long-term condition management is in general commissioned by CCGs, who do not, however, commission specialised HIV services and so are not sighted on the wider long-term support and care needs of people living with HIV.

The King's Fund report finds little evidence of system leadership at the local level for HIV. The report identified new models of care including STPs as offering 'opportunities for co-ordination of care between services and commissioners across the HIV pathway'. Every local area should, they recommend, have a shared and resourced plan for HIV services which draws on the frameworks of local health and wellbeing strategies and sustainability and transformation plans - 'STPs and health and wellbeing strategies offer overall frameworks for integrating services'.

Such fragmentation of healthcare is especially harmful for an ageing population of people living with HIV in England who will increasingly need integrated care as they experience elevated rates of co-morbidity and polypharmacy. One in three (30 per cent) people living with HIV is aged 50 or over.⁸ By 2028, this is projected to rise to more than half (54 per cent).⁹ The acquisition of both HIV-related and non-HIV-related co-morbidities among this ageing population creates a new dimension for the management of long-term conditions among people living with HIV. For example, among people living with HIV, high cholesterol is estimated to increase from 19% (2013) to 29% (2028) and hypertension will increase from 13% to 19%.¹⁰ Integrated care will be essential in supporting people living with HIV to navigate the health and social care system, and ensure a co-ordinated approach by healthcare

providers – ensuring well delivered care pathways between primary care, secondary care, HIV clinics, sexual health clinics, voluntary sector support services and social care.

An integrated approach to testing is also key to improving HIV health outcomes. An estimated 10,400 people living with HIV (more than 1 in 9) were unaware of their infection in 2016.¹¹ Although late diagnoses have decreased in recent years, still an estimated 42% of diagnoses were made at a late stage of infection in 2016.¹² Reducing undiagnosed and late-diagnosed HIV infection is an important factor in ensuring those with HIV are able to live as well as possible, as late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV.¹³ With effective HIV treatment now being prescribed immediately on diagnosis,¹⁴ and having the effect of making HIV untransmittable,¹⁵ most HIV transmissions are from the undiagnosed – so better testing is a key HIV prevention strategy.¹⁶ Testing is a service characterised by multiple commissioners having responsibilities in various and different healthcare settings, risking incoherent provision in the absence of an overall strategy.

WHAT IS AN STP?

Sustainability and Transformation Partnerships (STPs) have been established to enable every health and care system to come together to implement the NHS Five Year Forward View and especially its emphasis on ‘planning by place for local populations’ rather than ‘planning by individual institutions’.¹⁷ The focus is on integration of services and care around the individual patient and local population. STPs are 44 areas covering England where local NHS organisations and local authorities have come together to draw up proposals to improve health and care in the areas they serve. STPs have developed five-year plans

covering all aspects of NHS spending.¹⁸ Each STP covers an area with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million).¹⁹ It should be noted that STPs have no statutory basis and are not legal entities. As the LGA put it, ‘they derive their authority to act from the consent and participation of their participant organisations’.²⁰

STPs were required to provide detail in plans as to what they would do in their area to improve healthcare for their population. These plans were submitted to NHS England in 2016. The scope of the STP plans are broad. Initial guidance from NHS England set out three headline issues for STPs to look at in their plans; improving quality and developing new models of care, improving health and wellbeing, and improving efficiency of services.

STPs are designed to have the potential to secure greater collaboration and joint planning by different commissioners (NHS England, CCGs, local authorities), and as a result achieve improvements on those matters where there is shared commissioning responsibility. Greater alignment of plans and services will improve those services’ quality and efficiency.

NHS England requires all NHS bodies to engage with the STP process. The ambition is also that local authorities participate given their responsibilities for public health (including sexual health) and social care. The Local Government Association strongly supports the STP initiative and the vision for greater integration and effective place-based commissioning. But it is up to each local authority to decide to engage.

A more advanced version of the STP is the ‘Integrated Care System’, discussed in NHS England’s ‘Next Steps on the NHS Five Year Forward View’, where NHS organisations, in

partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.²¹

STPS' APPROACH TO HIV AND OTHER LESS COMMON CONDITIONS

The expectation is that STPs set out how they plan to address the 'three gaps' identified in the NHS Five Year Forward View:

- the health and wellbeing gap – the need to focus on prevention to maintain gains in life expectancy, reduce health inequalities and support a sustainable NHS;
- the care and quality gap – the need to address variation in quality, safety and outcomes by greater use of technology and innovation; and
- the funding and efficiency gap – the need to ensure the long-term financial sustainability of the NHS, with additional funding being used to improve efficiencies and transform services.

It is evident, however, from NHS England documents such as 'Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21',²² and the STPs progress dashboard, that there are some clear priorities for STP attention.²³ Financial sustainability, translated very often into tackling the deficit, looms large, as do waiting lists and addressing issues in primary and emergency care. In terms of health conditions, the emphasis is on cancer, mental health, dementia, learning disabilities and diabetes. It may therefore be unlikely that rarer conditions such as HIV will be prioritised when big issues are claiming immediate attention from what are still immature partnerships. However, STPs are intended to address both national and local priorities. There is a strong case in many areas for HIV to be attended to. This is

especially so given the emphasis in NHS England publications on prevention, empowering patients and whole person care.

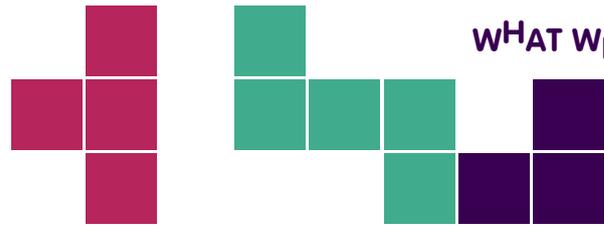
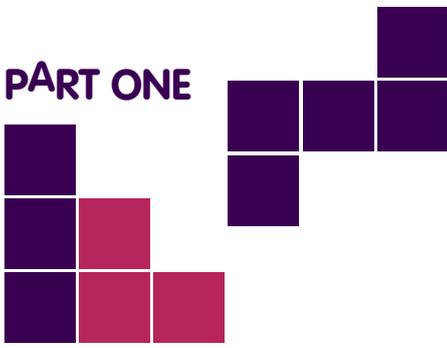
STPS THAT MENTION HIV

Seven STPs across England mentioned HIV in their 2016 plans. Four of the five London STPs mentioned HIV, and three outside London did. The seven are:

- North Central London²⁴
- North West London²⁵
- East London (formerly North East London)²⁶
- South East London²⁷
- Cambridgeshire and Peterborough²⁸
- Northamptonshire²⁹
- West Yorkshire and Harrogate.³⁰

We investigated in more detail the approach to HIV taken in these seven STPs. In addition, we included Greater Manchester as an example of an area where healthcare has been devolved and the newer models of care are more mature.

We are not claiming that these are the only STP areas where action is being taken to improve the integration of HIV care. Even where HIV is not explicitly mentioned there may be STP activity around a more generic issue which has the potential to benefit people living with or at risk of HIV, for example long-term condition management, or prevention. Focussing on those STPs which mention HIV in their published plans does, however, allow us to provide an initial snapshot of some current activity and the extent to which STP structures are being used to address HIV-related issues.



WHAT WE DID

We wanted to identify, support and promote local examples of integrated HIV care, with a focus especially on prompt diagnosis and on long-term condition management, across current commissioning innovations – devolution, collaborative commissioning and STPs. We reviewed all 44 STP plans and identified seven STPs that mentioned HIV in any context. We then decided to focus on these STPs, taking the mention of HIV in the plans as a sign that the STP was looking to proactively work on HIV-related issues.

Our approach was to gather information on how it came about that HIV is mentioned in the STP plan, the extent to which the local HIV sector and people living with HIV were consulted in the development of the STP plan, and what organisations knew of current planning and engagement at STP level in relation to HIV. We approached the following stakeholders in the STP areas to gather information:

- STP leaders
- Clinical leads at HIV clinics
- HIV support services (voluntary sector)
- Commissioners – both local authority sexual health and NHS England specialised commissioning.

In addition to developing eight case studies, one on each of the STP areas we focused on, we were also able to draw some overarching conclusions presented below. You can find more detail on the eight case studies in Part II of this briefing.

WHAT WE FOUND

LIMITED FOCUS IN STP PLANS ON HIV

We wanted to see if STPs can focus on a rarer condition such as HIV. HIV would really benefit from the integration STPs offer but does not feature on the STP progress dashboard of indicators and may well be overshadowed by the big questions of financial sustainability and more prevalent health challenges. The answer seems to be heartening to a degree – for example, London, the city with the highest prevalence of HIV in the country, does mention HIV in all its STP plans bar one (South West London). Mention of HIV in some STP plans has led to wide-ranging discussions on HIV at STP level, with work being considered, for example, in South East London on both HIV testing and long-term condition management. In another example, Greater Manchester has well-advanced plans to address HIV across local boundaries.

There are, however, other STP areas with high prevalence which did not mention HIV in their plans. In fact, we identified 17 STPs that did not mention HIV in their plans but had at least one high prevalence local authority within their boundaries in 2015, when the STP plans were developed.³¹ Whilst this does not necessarily mean nothing is happening (Brighton, for example, was the first UK city to sign up to the Fast-Track City initiative), it does mean that significant HIV prevalence is not sufficient to achieve STP focus on the issue.³²

There is some evidence of attention to HIV in STP-level plans in areas of high prevalence, in particular in London and Greater Manchester. HIV remains a relatively uncommon condition, even in areas of comparatively



LONDON, THE CITY WITH THE HIGHEST PREVALENCE OF HIV IN THE COUNTRY, DOES MENTION HIV IN ALL ITS STP PLANS BAR ONE

high prevalence. But it is, when untreated, an infectious condition and it remains costly to treat. Furthermore, it is strongly associated with multi-morbidity at a younger age. It disproportionately affects people with protected characteristics and is strongly associated with health inequalities. There is a consensus that people living with HIV have been hit especially hard by service fragmentation. These other considerations, and not just the bare numbers currently living with HIV, need also to be taken into account when considering the case for HIV inclusion in STP plans. Given these factors, more STPs with high HIV prevalence should have included HIV in their STP plans.

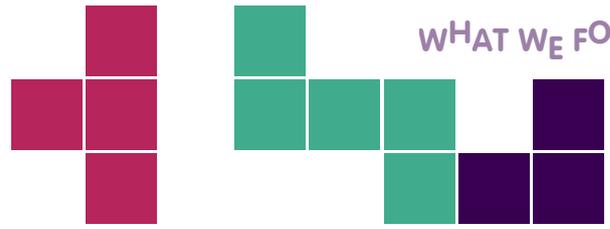
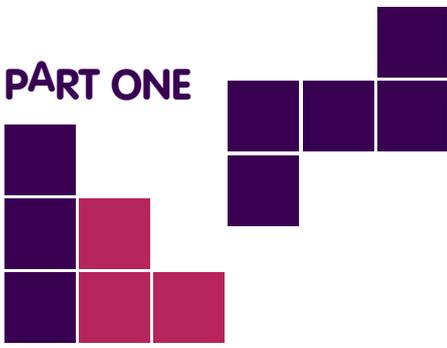
WHAT SECURES MENTION OF HIV IN STP PLANS

Very high prevalence is to a degree reflected in STP plans. Two further specific issues seem to have had traction in a few STPs – one was late HIV diagnosis and the impact on both prevention and treatment costs, and the other was specialised HIV clinical services, including their relation to sexual health services. But as important are local champions who believe the issue of HIV to be important, which is of course in any area to a degree a matter of chance. Similarly, activity since the publication of the plan appears to rely on stakeholders picking up on the opportunity afforded by the STP and running with it.

Greater Manchester underlines the extent to which proactive consideration of HIV in these new collaborative arrangements very much draws on what, if anything, had been in place previously to bring different parts of the HIV sector together across a wider geographical footprint.

For HIV to receive any attention in STP plans there had to be a combination of existing collaboration amongst HIV stakeholders, local champions with the vision and persistence to make it happen, and some traction with more generic issues already on the local commissioning agenda (for example, the wider prevention agenda which most STPs work on).

It seems less clear that consultation and engagement with people living with HIV and with HIV stakeholders had any direct impact on mentions of HIV in STP plans.



STPs HAVE NOT CONSULTED EFFECTIVELY WITH LOCAL HIV STAKEHOLDERS

In none of the STPs which mentioned HIV in their plans was there effective consultation with the HIV voluntary and community sector on the contents of the plan, either before the finalisation of the plan or since. The same seems to be true on the whole for consultation with local HIV and sexual health clinicians, certainly in advance of the STP plans being agreed. In some STPs there have been efforts around clinician engagement more recently, but these have mostly been generated from clinicians' own initiative rather than from the STPs themselves. This picture mirrors that reported by the King's Fund more widely. Greater Manchester is the one exception to this rule where in the development of its Population Health Plan there has been significant consultation with HIV stakeholders, building on its recent history of effective collaboration and involvement.³³

It is important to distinguish between STP-related engagement, for example on the contents of the plan, and engagement cited by respondents relating to specific projects, for example on the reconfiguration of HIV outpatient services within West Yorkshire. Such specific consultations are essential and important. They do not, however, substitute for engagement by the STP on how the health and care system as a whole should drive improved integration of care. Such STP-level engagement might elicit new information from people living with HIV and clinicians on problems with fragmentation, ideas on how to address them, as well as providing a much wider view of what constitutes genuinely integrated whole person care.

There was hardly any engagement with HIV stakeholders in the development of STP plans. STPs still need to do much more to



IN NONE OF THE STPs WHICH MENTIONED HIV IN THEIR PLANS WAS THERE EFFECTIVE CONSULTATION WITH THE HIV VOLUNTARY AND COMMUNITY SECTOR

consult with and engage local stakeholders such as HIV clinicians, the HIV voluntary and community sector and, above all, people living with and affected by HIV.

COLLABORATIVE WORK HAPPENED REGARDLESS OF STP INVOLVEMENT

One difficulty in assessing the possible contribution of STPs to better integration of care for people living with HIV is how to take account of collaborative activity which predates or coincides with the development of STPs, or indeed which takes place after the STP plan but which may well have taken place irrespective of the STP process. Some respondents claimed that all such work nowadays should be considered STP activity by default – 'anything done by our partners in the system is part of the STP'.

As was stated earlier, STPs have no legal basis – they are simply partnerships. This has an impact on their visibility and identity, and our ability to identify when the STP is engaged and making a difference.

We learned of a number of instances of such work from the STPs we looked at. For example, Northamptonshire told us of collaborative work to develop an integrated HIV and sexual health service; Cambridgeshire & Peterborough referred to educational work with GPs on HIV testing and cross-commissioner agreement to secure accessible HIV outpatient services; West Yorkshire & Harrogate told us about work on the reconfiguration of HIV specialised outpatient care; a number of London STPs referred to the work developing an integrated sexual health tariff; in East London STP commissioners are coming together to discuss how to reduce late HIV diagnosis.

Furthermore, both North Central London and South East London are beginning to think about people living with HIV and their long-term condition support, especially as they age. HIV clinicians are central to these discussions but there is some possible STP engagement. The STP plans were initial (and often rather hurried) ‘first stabs’ at assessing what needs to be done across this wider health and care footprint. It is good to see STPs maturing beyond the initial plan and an often costs-focussed approach, looking now more broadly at the health needs of their population.

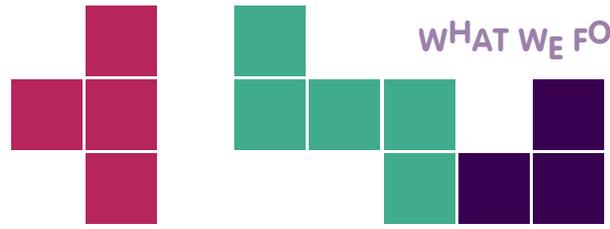
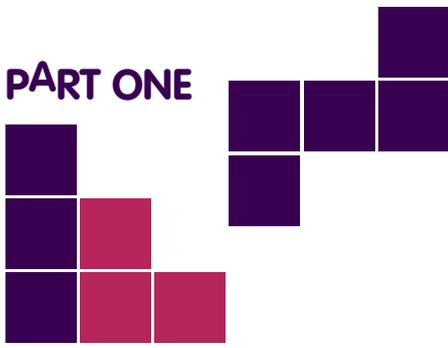
Despite such initiatives developing separately from formal STP arrangements, there was some acknowledgment of the ‘additionality’ STP processes and engagement might bring. Cambridgeshire & Peterborough spoke of the possibility of ‘opportunistic collaborative working’ if they were to align the work of the Sexual Health Delivery Board with the STP’s work and Northamptonshire is hoping that their STP’s

‘direction of travel’ will allow further work on sexual health and on HIV as a long-term condition. STP structures can possibly provide a home for shared governance, getting system leaders together, and providing focus on various potential models for collaborative commissioning.

Further assessment is needed as to how STPs might develop already existing integration initiatives. We note that in the absence of STP involvement, integration projects cited tend to be amongst commissioners already engaged on HIV and sexual health. There is an opportunity for STPs to ‘push the envelope’ and involve commissioners around, for example, mental health, social care, primary care and long-term condition management.



IT CAN BE DIFFICULT TO ASSESS WHETHER AND HOW STPS ARE ACTUALLY INVOLVED IN LOCAL COLLABORATIVE INITIATIVES TO INTEGRATE CARE – AND WE MUST PROBABLY ACCEPT THAT WILL OFTEN BE A GREY AREA.



It can be difficult to assess whether and how STPs are actually involved in local collaborative initiatives to integrate care – and we must probably accept this will often be a grey area. But there was in our survey a consistent ambition for greater STP engagement on HIV and belief it can afford benefits.

Stakeholders should continue to consider ways of collaborating to improve co-ordination along the HIV care pathway regardless of involvement from the STP itself. Good HIV-related collaborative working outside explicit STP processes has the potential, however, to be a jumping-off point for consideration of HIV by the whole health and care system within the STP.

We look forward to further evidence of how STPs make a difference as plans are implemented. We would especially encourage STPs to engage commissioners who have not traditionally thought much if at all about the needs of people living with HIV.

STPS MUST DO MORE TO ADDRESS LATE HIV DIAGNOSIS AND THE CHALLENGES OF LIVING WITH HIV AS A LONG-TERM CONDITION

In some STPs the brief mention of HIV in the plan does not appear as yet to be reflected in any STP-level activity. With the exception of Greater Manchester, most HIV-related work at STP-level seems to be at an early stage of development. We note also Greater Manchester has the advantage of a proportion of their transformation funding going to HIV work.

It has been disappointing to see the lack of engagement in STPs on HIV as a long-term condition, with the associated issues of ageing and multi-morbidity, and the challenge of integration of HIV not only with sexual health services, but also with primary care and other specialist secondary care. Integrated care pathways and effective support services will involve a wide range of commissioners and providers. They have the potential to significantly improve quality of life and deliver efficiency savings to health and social care. We hope initial interest in this issue within both the North Central London STP and the South East London STP bears fruit. It is good to see the possibility of some Greater Manchester-wide attention to this issue through the PaSH service. South East London STP interestingly mentioned their desire to work on long-term condition management for people living with HIV, but were attempting to work out what could be best done when evidence on best practice is currently limited. There is therefore scope for stakeholders to contribute to the evidence base by developing plans for better HIV management and measure whether health outcomes improve as a result.

Testing and reducing late diagnosis seem to be a theme common to many of the plans and activity – North Central London, East London, South East London, Northamptonshire and Greater Manchester. It is good to note the extent to which poor local performance against the Public Health Outcomes Framework (PHOF) indicator and Public Health England (PHE) benchmarking has had an impact in inclusion of HIV in STPs. There are, however, too many other poor performing areas of the country which have not addressed HIV in their STPs despite the PHOF.

North Central London have a challenging target of halving late diagnoses in their area. The economic case for action on late diagnosis was, we were

told, important in securing inclusion in their STP. The evidence of planning to reduce late diagnosis across local authority boundaries is very encouraging, as is in Greater Manchester the new funding available to community testing and other testing initiatives such as more self-testing and self-sampling. Whilst it is still early days in terms of concrete changes, it was especially good to see reference in the East London STP plan both to online self-sampling and also to testing in primary care. If STPs are to fulfil their potential for integration they need to catalyse interventions in new and differently commissioned settings such as these.

Reference to specialised HIV clinical services seems to be either in the context of the overall sustainability of secondary care trusts in the STP area, and/or to the question of how to ensure planning is coordinated with sexual health service provision (which latter point raises issues of sustainability of HIV clinic services as well as convenience and effectiveness of service for patients).

It is too early to describe with confidence what, if anything, will emerge concretely on HIV in those STPs which do mention HIV in their plans. Frequent reference to HIV testing and reducing late diagnosis is encouraging (especially in the more developed plans in Greater Manchester). We hope it will involve commissioners such as CCGs and NHS England, who may not have been engaged on HIV testing to date, introducing testing in new settings such as hospitals (outside the sexual health clinic) and GP practices in line with NICE guidance.

The relative neglect of the long-term condition needs of people living with HIV in STPs is a serious concern given that their whole person care has to date suffered so much from fragmentation and urgently needs attention at

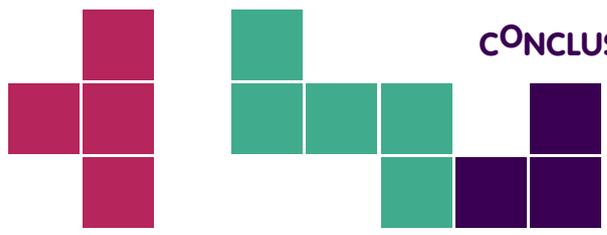
STP level to improve integration. We strongly encourage the initial work on this issue in North Central London and South East London STPs, and believe many other STPs should follow their example.

Overall, even in this small sample of STPs which mention HIV in their plans, the variation in HIV-related activity, even amongst those with high prevalence, is striking and a matter for concern. We trust in London that the Fast-Track City Initiative might 'level upwards' more consistent STP engagement. More generally, there needs to be a process whereby STPs learn from each other and share good practice and models of success.

STAKEHOLDERS MUST TAKE THE LEAD IN ENGAGING WITH STPS

While STPs like South East London have more recently initiated conversations with local stakeholders in their area, most conversations that have started around HIV at STP level have been the result of clinicians taking the initiative and approaching the STP themselves, rather than the other way around. It seems that a bottom up approach is needed to leverage the STP to proactively work on HIV. For example, Cambridgeshire and Peterborough STP stated that "if one of the neighbourhoods, based on an assessment of population needs, prioritises an opportunity to improve care for people with HIV, the system would support this".³⁴ In Greater Manchester, progress was due initially to the good work of stakeholders in the area capitalising on the opportunities that devolution brought rather than the Greater Manchester Health and Social Care Partnership (GMHSCP) approaching stakeholders to ensure HIV was captured as part of the population health plan.

It seems that for rarer conditions such as HIV, where STPs will not automatically designate the condition as a priority, one way to work with STPs would be for stakeholders to come together and develop proposals that they then take to the STP, capitalising on opportunities that various STP workstreams might present.



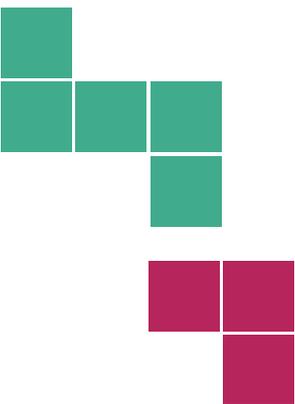
CONCLUSION

HIV can be considered at STP level, with plans for improvement formulated, if:

- local HIV stakeholders independently develop mechanisms for collaboration, integration and networking,
- arguments for an HIV-focus in STPs build on local HIV data and assessment of need, economic arguments, reference to nationally agreed performance indicators and generic policy priorities of the STP, and
- local HIV stakeholders take the initiative in developing proposals for STP consideration, and persist in advocating for them.

STPs will not in and of themselves fix the current fragmentation in HIV care. They at best provide a framework within which the responsible bodies (NHS England, CCGs, local authorities, Public Health England, and local providers) can improve integration.

We very much hope that people living with and affected by HIV, and colleagues working on HIV, are encouraged to develop proposals for STPs to improve integration of HIV care. NAT believes STPs have potential to secure such improvements.



HIV AND STP PLANS

NORTH CENTRAL LONDON

HIV STATISTICS FOR NORTH CENTRAL LONDON

North Central London STP (now known as North London Partners) covers an area of five local authorities; Barnet, Camden, Enfield, Haringey and Islington. All areas are high HIV prevalence areas with the lowest being Barnet with 2.94 per 1,000.³⁵ Camden, Haringey and Islington are all areas with extremely high HIV prevalence (more than 5 per 1,000) with the rates being 8.62, 6.71 and 7.74 per 1,000 respectively.³⁶ Enfield has a HIV prevalence of 3.95 per 1,000.³⁷ All the areas have below average rates of late diagnosis other than Enfield which has a high late diagnosis rate of 50.4%.³⁸

The area also covers five CCGs: Barnet, Camden, Enfield, Haringey and Islington.

HIV IN THE STP

HIV is mentioned in the STP plan briefly twice. The first is within a section on prevention, detailing what the STP will do to “embed prevention and early intervention across the whole health and care system and deliver effective preventative interventions at scale”.³⁹ One specific aim of this stream of work is “diagnosing residents with clinical risk factors and long-term conditions much earlier to increase life expectancy” – of which HIV testing is one key intervention.⁴⁰

The second mention is within a section on providing health and care ‘closer to home’ where the aim is that “health and care will be available closer to home for all, ensuring that people receive

care in the best possible setting at a local level and with local accountability”.⁴¹ By providing care closer to people’s homes the STP states that they have identified a number of outcomes on which they can build improvement as “improving outcomes will be the crucial measure of success of the care closer to home model”.⁴² One of these outcomes is “a halving of the numbers of late HIV diagnoses”.⁴³ Part of the aim of the care closer to home model is a ‘place-based’ population health system of care delivery which draws together social, community, primary and specialist services.⁴⁴ While it remains unclear as to exactly how the care closer to home model will be relevant to reducing late HIV diagnoses, we speculate that this could mean an increase in self-sampling/self-testing and/or an increase in testing in a variety of settings such as in primary care, a key setting in which to diagnose HIV.

STAKEHOLDER ENGAGEMENT

None of the HIV clinical leads at North Middlesex University Hospital (NMUH), Royal Free Hospital (RFH) or Central and North-West London (CNWL) were consulted on the development of the STP plan. However, one clinician suggested that the mention of HIV in the plans might be in part due to the chair of the STP and CEO of the Royal Free London Group, who has in the past been very mindful of HIV and supportive of keeping it on the agenda.

The three clinical leads at the HIV clinics in NMUH, RFH and CNWL had begun investigating how they could leverage the STP to improve HIV services. NHS England Specialised Commissioners had encouraged the Trusts to organise workshops on HIV at STP level in 2018, involving a range of stakeholders including service users and primary care – where the focus would be less about

HIV prevention and testing, and more about improving and integrating clinical services. These workshops have not yet happened. Priorities for service developments to be discussed at these workshops had been identified by the clinicians. These priorities are community-based support and mental health services within HIV clinics. Conveniently for the HIV clinics the STP footprint matches the existing North Central London HIV clinical network, however it was mentioned that the footprint does not match the sexual health or hepatitis C clinical networks, which could present barriers to joined up working.

The main HIV support services in the area, Positively UK and THT, had also not been consulted by the STP in the development of the STP plan.

However, local authority sexual health commissioners appeared to be well connected with the STP with regards work on the STP's aim to reduce late diagnosis. We received a letter from the Director of Public Health for Islington, on behalf of all London Boroughs within the area, that mentioned that they were aware of and involved in the development of the prevention workstream, and that whilst the plans for engagement are currently under development, commissioners receive monthly updates from the Programme Management Office of the STP through newsletters. Public health consultants from across North Central London are members of the STP's Prevention Board, which meets quarterly, and members are presented with an update on progress of the Prevention programme of work and how plans to reduce late diagnosis of HIV are going.

CURRENT STP PLANNING AROUND HIV

The STP lead for North Central London said that the STP's prevention workstream, including the proposal to reduce late diagnosis of HIV, drew on local needs analyses and an economic assessment of interventions likely to be highly cost-effective and potentially cost saving over the STP's five-year timescale.

In terms of engagement with local stakeholders, the STP lead stated that North London Partners (North Central London STP) have dedicated leads for communications and engagement across the STP - and the plans for engagement are currently under development. There might be, therefore, an opportunity for more local HIV stakeholders to be involved in shaping work around the HIV outcome of halving late diagnoses.

COMMENTS

Despite most areas within this STP having lower than benchmarked rates of late diagnosis, it is commendable that the STP has a target of halving late diagnoses, particularly when the area as a whole has such high prevalence rates.

It appears that there are opportunities within this STP for multiple pieces of work to be going on at STP level on HIV. First that of reducing HIV late diagnoses as part of the STP prevention workstream. Secondly, that of the HIV clinics looking to use the STP to support improvement of HIV treatment services by identifying priorities such as community-based support and mental health services within clinics. Though, of course, the STP itself is yet to engage with this second opportunity.

It is also unclear at this stage what roster of activities the STP partners will undertake in order to

reduce late diagnosis rates. We trust not only local authorities, but NHS England and the local CCGs will contribute to activity. These activities should also be shaped by a range of stakeholders, and hopefully the STP will look to engage HIV clinicians and communities disproportionately affected by HIV within their discussion. This example shows that for HIV, a relatively rare condition in comparison to the main conditions NHS England have designated as priorities for the system (cancer, diabetes, mental health for example), there are still opportunities at STP level for HIV work to be supported. We wait to see what will come of this work.

NORTH WEST LONDON

HIV STATISTICS FOR NORTH WEST LONDON

The North West London STP covers an area of eight local authorities; Brent, Ealing, Hounslow, Hillingdon, Harrow, Westminster, Hammersmith and Fulham, Kensington and Chelsea. All local authorities in North West London have a high HIV prevalence, ranging from the lowest in Harrow (2.37 per 1,000) to the highest in Kensington and Chelsea (9.45 per 1,000).⁴⁵ Two local authorities have higher (worse) than national average late diagnosis rates, Hillingdon with 44.2%, and Harrow on 43.5%, with the lowest late diagnosis rate in the STP area being Westminster on 25.9%.⁴⁶

The STP footprint also cover eight CCGs: Brent, Central London, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, West London.

HIV IN THE STP

Within the STP plan there are five overarching delivery areas. HIV is briefly mentioned in a section

on delivery area five - "ensuring we have safe, high quality sustainable acute services".⁴⁷ The STP is looking at services commissioned via NHS England's Specialised Commissioning budget (of which HIV treatment is one). The North-West London STP will look to complete a specialised commissioning service review of HIV that they had started and will begin to implement the findings from this review.⁴⁸ The plan does not provide much detail as to what the scope of this review is or when the review is likely to be completed.

The STP plan also mentions using the levers of CQUIN and QIPP to improve efficiency and quality of care for patients through a focus on various different elements of care including cost effective HIV prescribing. CQUIN stands for Commissioning for Quality and Innovation, and was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.⁴⁹ QIPP (Quality, Innovation, Productivity and Prevention) similarly is a programme of work in the NHS to drive improvement in healthcare while simultaneously making efficiency savings.⁵⁰

STAKEHOLDER ENGAGEMENT

While HIV clinical leads were not consulted in the development of the HIV mention in the STP plan, clinical leads informed us of a meeting that was held with North West London services in January 2017, organised by NHS England to discuss how the STP could work on HIV issues in the area. The meetings looked at using the STP framework and resources that were being put into STP to support HIV services to make spending savings. A mapping exercise was carried out on how much the services were costing, looking at per patient how expensive the services were, and where services could make savings. One clinician's view was that saving money was the main focus

of the meetings, and that while funding might be available for management training it was unlikely to go to service development. This contrasts to the meetings that NHS England have encouraged their clinicians to organise, with the focus there on clinical services and patient care rather than simply saving money.

We attended the London HIV Clinical Forum in March 2018 where clinicians in this STP area stated that the STP appears to be focused upon inpatient models of care for HIV and not much else. There was a general feeling amongst clinicians of a lack of output from the STPs.

HIV voluntary sector support services in the area include Living Well CIC, NAZ, and River House Trust (formerly the Cara Trust and River House who have merged), none of whom were consulted in the development of the STP plan.

CURRENT STP PLANNING AROUND HIV

North West London STP did not respond to our letter asking them what the current planning was for HIV services in the area – so it is unclear whether the specialised commissioning service review of HIV has been completed, what work this entails and whether findings from the review have shaped the development of services.

Brent was the one local authority in the STP area that responded. They mentioned that the STP workstream on public health is currently focused on social isolation and the causal factors such as alcohol, obesity, mental health and a lack of social networks – funding for this project started in April 2018. There are no plans to work on HIV through this workstream at this time.

COMMENTS

Neither clinicians nor voluntary sector services appeared to have been engaged that well by the STP, which is disappointing given both the mention of HIV in the STP plan and the high prevalence rates in the area. This highlights the difficulty of leveraging the STP particularly when there are competing priorities for the STP to look at and where service developments for those in relation to more common conditions probably offer more opportunity for financial savings – which the North West STP seems particularly focused upon. And while there was an initial meeting between clinicians and NHS England, it appears that not much work has been taken forward on HIV in the meantime.

It appears that HIV is mentioned only within the context of efficiency and financial savings for specialised commissioning by reducing the costs associated with HIV treatment in North West London. While we do not dispute the importance of improving efficiencies across the healthcare system where possible, we would have welcomed more patient-focused outcomes and areas of improvement for HIV, responding to the needs of their local population.

EAST LONDON

HIV STATISTICS FOR EAST LONDON

East London Health and Care Partnership (formerly called North East London STP) covers an area of eight local authorities: Barking and Dagenham, City of London Corporation, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. All local authorities within the STP are considered high prevalence areas,

with prevalence rates ranging from 2.72 per 1,000 in Redbridge to as high as 11.23 per 1,000 in the City of London.⁵¹ The HIV late diagnosis rate ranges from a low of 18.2% in Tower Hamlets (much lower than the national rate of 40.1%) to a high of 53.9% in the City of London.⁵²

The STP also covers seven CCGs: Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest.

HIV IN THE STP

There is mention of HIV in the East London STP plan within a section entitled 'Transforming sexual health services.'⁵³ They mention that the STP area experiences high prevalence rates for common STIs relative to England and London, including HIV, and some areas of North East London are diagnosing HIV later than average.⁵⁴

The STP plan also seeks to recognise the need to work collaboratively at scale to successfully improve access and outcomes, due to the high number of residents within the STP area that access sexual health services in central London (due to a mobile population and open access services).⁵⁵ The STP recognises the need to work on a larger footprint so that commissioners and providers can work collaboratively across a given footprint, particularly if residents from certain localities within the STP are likely to access sexual health services in different localities from which they live. As a result, they are working with the London Sexual Health Transformation Programme (LSHTP) - and so far, the North East London Sexual Health Transformation Programme has been formed across Newham, Redbridge, Tower Hamlets and Waltham Forest – overcoming these challenges by jointly planning and commissioning integrated sexual health services.

The STP identifies a number of opportunities

for improving sexual health services in the area including; improving access to STI diagnostics outside the acute environment such as self-sampling available online and in primary care, creating appropriate STI treatment opportunities, and developing effective partner notification which is mindful of the LSHTP model and is fit for purpose for North East London.⁵⁶

STAKEHOLDER ENGAGEMENT

There was no formal consultation with HIV stakeholders in the area in the development of the STP plan and thus far there has been no engagement from the STP mechanism itself with HIV stakeholders in order to take workstreams forward.

There is already an established North-East London HIV network that regularly meets to discuss opportunities to tackle HIV in the area in collaboration. This network includes HIV clinicians, voluntary sector services, Public Health England representatives and patient representatives – and the network covers the same geography as the STP. The network at the time of writing has plans to reach out to the STP to establish contact. Members of the network we talked to expressed frustration at the lack of engagement from the STP and stated that it remained unclear how STPs are meant to support service development in practice. Previous attempts had been made to invite STP representatives and stakeholders with responsibility for commissioning and co-ordinating the improvement of services to a North-East London HIV network meeting. While the network did manage to secure representation from local authority sexual health commissioners, no one representing the STP has yet attended.

Stakeholders suggested that the reason HIV was mentioned at all in the plans was most likely due to a link with a senior manager at NHS England who

has been enthusiastic about taking HIV forward as an area for health improvement in the STP.

better joined up and expansive approaches to testing.

CURRENT STP PLANNING AROUND HIV

The STP did not respond to our letter. However, we spoke to local authority sexual health commissioners about current planning and engagement at the STP level. Tower Hamlets commissioners are currently leading on a piece of work on reducing HIV late diagnosis (and increasing testing) – this is currently between Tower Hamlets, Waltham Forrest, Newham and Redbridge (and related NHS Trusts and local voluntary sector providers) who already work together in the inner-city area. They have also reached out to Havering and Barking & Dagenham to try to make this work across the entire STP footprint. The mechanism of the STP is not supporting the piece of work financially, but commissioners are calling it ‘STP work’ as it is all about joining up the approach to commissioning to maximise the benefits of interventions of whole populations. This is an example of where the STP itself may not be actively supporting the work going on between partners in the area, but the move to a more integrated healthcare system has nevertheless encouraged partnership working at a local level regardless of whether there is top down financial or systematic support.

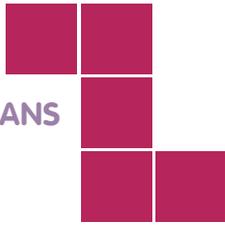
COMMENTS

This is another example (along with Northamptonshire and North Central London) where the STP has mentioned the late diagnosis rate briefly in the STP plan. HIV stakeholders such as the local authority commissioners in the area have attempted to capitalise on this mention of HIV, looking to integrate services to ensure

However, while the HIV clinical network has also attempted to engage the STP so far, nothing yet has come of inviting an STP representative to their network meeting. This highlights the danger that mentions of HIV (on any condition for that matter) in STP plans become simply tokenistic gestures rather than genuine areas of work, unless HIV stakeholders in the area can come together to lobby the STP, which obviously requires significant time and resource from clinicians and other stakeholders whose capacity is already stretched. Most clinicians we spoke to in East London did not feel hopeful that the STP mechanism could serve to promote integration for HIV services, stating that the STP process appeared opaque and difficult to engage with.



MOST CLINICIANS WE SPOKE TO IN EAST LONDON DID NOT FEEL HOPEFUL THAT THE STP MECHANISM COULD SERVE TO PROMOTE INTEGRATION FOR HIV SERVICES



SOUTH EAST LONDON

South East London STP (also known as Our Healthier South East London) contains six local authorities; Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. All six are high prevalence areas with Lambeth having a prevalence of 16.4 per 1,000, the highest of any area in England.⁵⁷ Lewisham and Southwark are also extremely high prevalence areas with rates of 7.99 and 11.51 per 1,000 respectively.⁵⁸ The lowest prevalence rate is that of Bexley (2.61 per 1,000).⁵⁹ All areas have a late diagnosis rate below that of the national average bar Bexley with a high late diagnosis rate of 56.1%.⁶⁰ The lowest late diagnosis rate in the area is Lambeth on 28.2%.⁶¹

The STP footprint also covers six CCGs: Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark.

HIV IN THE STP

HIV is mentioned briefly in the STP plan in a section on 'Pathway Transformation' in which the STP is "reviewing how we deliver the most effective and high performing services".⁶² The Specialised Commissioning Appendix sets out the areas of initial focus at a pan London and South-East London level. The Priority areas are "Paediatrics, Cardiovascular, Specialist Cancer, Renal, Neuro-rehabilitation, Neuro-surgery, Vascular Services, HIV, Adult secure mental health, CAMHS [Children and Adolescent Mental Health Services] and Transforming Care Partnerships".

With regards sexual health, the STP is focused on the following interventions; adopting an integrated sexual health tariff; providing an online service offer; shifting services to primary care; and targeting prevention and increased detection to groups with the highest rate of infections. Sexual

health has been identified by South East London as one of the six priority areas for prevention.⁶³

STAKEHOLDER ENGAGEMENT

Whilst the STP did undertake extensive engagement with patients and the public to inform the development of the strategy, clinicians stated that there was no specific consultation with the HIV stakeholders in the area on mentioning HIV in the plan. However, it was a very welcome move, and most thought the mention was a result of the areas exceptionally high prevalence rates. One support service explained that at the political level, elected members for the area are very engaged with HIV as an issue, as are CCG members, and there are significant mentions of HIV and sexual health at CCG level and at primary care committees.

CURRENT STP PLANNING AROUND HIV

The STP advised us that across the South East London STP boroughs there is already a strong partnership and governance around sexual health, with work already having taken place in the last few years on introducing an online sexual health service and consolidating sexual health clinics in Lambeth and Southwark.

The STP informed us that a consultation will be launched in the autumn for Lambeth, Southwark and Lewisham's new Sexual and Reproductive health strategy which is focused around four pillars of action:

1. Safe, healthy and fulfilling relationships
2. Good reproductive health across the life course
3. High quality STI testing and treatment
4. Living well with HIV.

Furthermore, Lambeth, Southwark and Lewisham in partnership with the Elton John AIDS Foundation have launched a £3 million testing and retention in care social impact bond (SIB), which aims to increase testing in hospitals, primary care and community.⁶⁴

Lambeth, Southwark and Lewisham also jointly commission the RISE partnership (NAZ, Race Equality Foundation, Antidote and GMFA) which conducts outreach to black and minority ethnic populations as well as to certain groups of MSM, particularly those engaging in chemsex.

It will be interesting to see how well-established collaboration between inner boroughs in this STP around sexual health and HIV is extended and developed across this wider STP footprint.

HIV clinicians informed us that they had met with the chair of Southwark CCG and members of the STP Transformation Board – the largest board in the STP looking at delivering change to clinical services. Reflecting on the quality of services currently delivered, large-scale transformation of HIV is not identified as a current priority for the STP. Instead the STP is focusing on retention in care and diagnosing the undiagnosed in settings outside GU clinics.

The Chief Operating Officer (COO) at the STP informed us of how HIV sits within the STP's workstream called 'Community Based Care'. This workstream looks at local care networks, prevention and primary care. HIV testing fits specifically within the prevention section. The chair for Southwark CCG is a particular driving force for getting the STP to work on testing, and they have a particular focus on 'new entrants' - either to the UK or South East London, a group that have been identified as likely to be diagnosed only once they have clinical indicator conditions. HIV as a long-term condition fits within the community-based care workstream's focus on long-term

conditions and the STP especially wants to tackle fragmentation across the HIV care pathway.

The COO mentioned that a lot of the conversations around long-term condition management thus far have been focused on the opportunities that might exist if NHSE Specialised Commissioning devolved funding for HIV to CCGs, which might allow the CCGs more freedom to deliver the services in innovative ways where they might not be bound as strictly to the service specification that NHSE developed for HIV services.⁶⁵ However, clinicians in the area have stated that many of their patients are now reaching old age, co-morbidity and polypharmacy is a key issue for many, and due to the fact that there is little evidence base for what good long-term condition management looks like, specialist support (commissioned through the specialised services budget) for people living with HIV might be more crucial than ever. There is little current evidence to guide the best approach for older age people living with HIV with co-morbidities, and as such it is difficult to determine the best commissioning model.

With regards voluntary sector involvement, the COO stated that support services are often represented by patients on their Patient and Public Advisory Group. However, support services weren't currently as involved in the direction of service change for HIV as they were for other conditions such as diabetes.

COMMENTS

Given the extremely high rates of HIV within the footprint it is encouraging that the STP has plans on developing services both for testing and for long-term condition management. The STP appears to be more mature than most we have spoken to, already having concrete plans for developing HIV services at a relatively granular

level – for example the focus of increased testing amongst ‘new entrants’.

While we understand the STP’s interest in taking more commissioning responsibility of the HIV treatment budget, we have in the past voiced concern about the devolution of NHS England Specialised Commissioning budgets to CCG level. NAT have been concerned that there is a real risk that pooling budgets could lead to lack of budgetary accountability about how specialised services were actually being spent on local services and that devolution of budgets could undermine consistent funding of specialised services in line with national policies – raising questions over how the current NHS England process for decision-making and setting specialised policies would apply when they are not the responsible commissioner in a given area. We would be concerned if national service specifications did not still apply. However, we know that some of the budget for HIV treatment services have already been devolved to Greater Manchester. There may be some key learnings from devolution there of importance to other STP areas, such as South East London, looking to gain more financial control over HIV treatment budgets – which may have a positive impact upon health outcomes if designed to support more joined up care.

CAMBRIDGESHIRE AND PETERBOROUGH

HIV STATISTICS FOR CAMBRIDGESHIRE AND PETERBOROUGH

In 2016, Cambridgeshire had a diagnosed HIV prevalence of 1.14, and Peterborough had a

prevalence rate of 2.06 making it a high prevalence local authority.⁶⁶ Cambridgeshire had a late diagnosis rate of 51.1% and Peterborough of 50%, making them among three local authorities to have a late diagnosis rate of 50% or higher in the East of England region (Bedford being the other).

The STP footprint also covers a single CCG: Cambridgeshire and Peterborough CCG, one of the largest CCGs in England by patient population.

HIV IN THE STP

There is only a very brief mention of HIV in the STP plan, in the section on ‘Culture of Learning as a System’, which is one of the STP’s ‘four key enablers’ to secure savings and improvements.⁶⁷ There is an emphasis on learning being shared and owned across the whole STP health and social care system. A core part of the STP’s cultural identity is identified as ‘learning’ – ‘We will continue to strive for excellence in the care we provide for the patients of today. We also need to be at the forefront of adopting new therapies and delivery models for the patients of tomorrow’.⁶⁸ The STP plan states that the Cambridgeshire Community Services NHS Trust (CCS) ‘will continue to develop its research and innovation in sexual health, HIV care, and children and young people’s services’.⁶⁹

The Executive Director for the STP system delivery unit told us that ‘HIV was mentioned as an example of a service which cuts across local authorities, community health and secondary care providers’.⁷⁰

It is important to stress that limited engagement on HIV within formal STP structures does not mean there is no collaborative and integrated working going on. Indeed, the view was that ‘anything done by our partners in the system is part of the STP’. We were given the examples of a section 75 agreement between Cambridgeshire

County Council and NHS England around accessible HIV outpatient services, the work of the Cambridgeshire and Peterborough Sexual Health Delivery Board, and educational work to support improved HIV testing in General Practice. But we were also told that 'Aligning the Sexual Health Delivery Board with the appropriate STP stream would provide opportunistic collaborative working'. That final comment underscores the challenge when trying to identify the 'additionality' of STPs in securing improved integration. If any collaborative work, often predating STP development, can now be described as STP activity, it is hard to see what if any difference the development of STPs has made, or how STP plans and structures can be harnessed to make things better. But there is in that final comment acknowledgment that the STP process does offer further opportunities for collaboration, perhaps, for example, with parts of the system less used to integrating with HIV and sexual health services.

STAKEHOLDER ENGAGEMENT

Neither Diverse nor THT, the two main Voluntary, Community and Social Enterprise (VCSE) organisations working in this STP area, had been consulted about or were aware of the mention of HIV within the STP plan, nor had had any contact with the STP process. The Executive Director of the STP system delivery unit confirmed there had been no targeted outreach to local HIV organisations. We did not receive any information on consultation locally with HIV clinicians on the STP plan.

Commissioners emphasised the important role the VCSE sector has locally in the prevention and treatment of HIV. A range of services are commissioned by Cambridgeshire County Council and Peterborough City Council around late diagnosis, stigma, pathways into care, and health and social care support. CCS NHS Trust works

in partnership with community organisations on health promotion and targeted outreach work with vulnerable groups and in public sex environments. This is very welcome – but it will be important to build on these relationships and formally seek ideas both from these organisations and from service users on how HIV-related services can be further integrated effectively to improve outcomes.

CURRENT STP PLANNING AROUND HIV

The STP Executive Director explained that HIV is not an explicit priority for the STP, which is one of the most financially challenged and so is focussing on reducing emergency demand and delayed transfers of care. They are, however, also starting to 'develop holistic approaches to managing local population needs – be these medical (e.g respiratory) or social (e.g isolation). Therefore ... if one of the neighbourhoods, based on an assessment of population needs, prioritises an opportunity to improve care for people with HIV, the system would support this'.⁷¹

COMMENTS

The reference to HIV in this STP plan is very brief and HIV is clearly not currently a priority for Cambridgeshire and Peterborough STP. This again demonstrates the challenge, even in STP areas which include high prevalence local authorities⁷² and significant late diagnosis rates, of getting a focus on HIV, a less common condition, when the pressure is around securing larger scale wins to achieve financial stability.

Is there however potential to build on this brief reference and secure some degree of engagement on HIV at the STP level? Two approaches seem to have potential, based on the documentation

reviewed and replies received to our enquiries. One is for the sexual health/HIV clinical teams within CCS NHS Trust to work with stakeholders and identify further innovation in sexual health and HIV care, as encouraged in the STP plan. Can some of that innovation around 'new therapies and delivery models for the patients of tomorrow' address aspects of the care pathway where currently there is fragmented commissioning and provision?

Furthermore, the Cambridgeshire and Peterborough system is one of two areas selected for a national pilot study of integrated sexual and reproductive health commissioning during 2018/19, and will be working closely with Public Health England, NHS England, the CCG Commissioners, providers and other stakeholders on such issues as prevention/early intervention, late diagnosis and patient pathways. This is clearly an important opportunity for improved integration around HIV testing and sexual and reproductive health services for people living with HIV.

It was also good to see the openness of the STP's Executive Director to HIV-related proposals for work at neighbourhood level to secure more holistic care. It seems that STPs, especially in relation to HIV, will more commonly be processes and systems within which local HIV stakeholders have to take the initiative and come up with solutions to issues of fragmentation in the care pathway – for the STP then to consider.

NORTHAMPTONSHIRE

HIV STATISTICS FOR NORTHAMPTONSHIRE

Northamptonshire had in 2016 a diagnosed HIV prevalence of 2.11 per 1,000, making it a high

prevalence local authority area.⁷³ In 2016 there were 41 new HIV diagnoses, which equates to 6.9 per 100,000 people aged between 15 and 59.⁷⁴ The HIV late diagnosis rate over a three-year period between 2014 and 2016 was 47.5% which means it was similar to (though a bit higher than) the national rate of 40.1%.⁷⁵

It should be noted that in this instance the Northamptonshire Health and Care Partnership (previously, 'STP') area covers a single local authority, Northamptonshire County Council, and two CCGs, NHS Corby and NHS Nene.

HIV IN THE STP

There is one mention of HIV in the STP, in the context of one of their four 'key initiatives' which is 'Systematic, personalised and proactive prevention at scale'.⁷⁶ This includes developing a comprehensive county-wide prevention programme, which will aim to see improvements in 'screening and imm[unisation]s (national and local [HIV])'.⁷⁷ The document is brief so there is no further content to expand on the bracketed mention of HIV, but NAT hopes this means there is some ambition to reduce late HIV diagnosis rates further, which would both improve the health outcomes of people with undiagnosed HIV and prevent further onward transmissions.

The local authority Public Health team and the VCSE sector led and wrote the 'systematic, personalised and proactive prevention at scale' elements of the STP plan. The Public Health team included content on HIV testing as at the time Northamptonshire had a worse than nationally benchmarked late diagnosis rate.

The clinician response referred us to the public health commissioner for more detailed information on the planned integrated sexual health and HIV service. A number of respondents mentioned

that the local STP was in a very early stage of development.

STAKEHOLDER ENGAGEMENT

Whilst we were told that the VCSE sector more broadly were involved in the writing of the STP plan, NAT is not aware if any HIV organisations were consulted. There is no funding for HIV support services from the local authority and as a result we are not aware of any VCSE organisations specialising in HIV currently providing services there. In the absence of such organisations, it was even more important that efforts be made to hear from people living with HIV when developing the plan. Given the stigma and marginalisation experienced by many people living with HIV, this would need to go beyond more general invitations to engage.

CURRENT STP PLANNING AROUND HIV

Separately from the STP initiative, there has been ongoing discussion and collaborative work between NHS England specialised commissioning, Northamptonshire County Council and the local CCGs. Currently NHS England and Northamptonshire County Council are in the process of developing an integrated sexual health and HIV service, finalising joint procurement and a section 75 agreement to formalise the commissioning model of service delivery. HIV testing is currently provided in the main through sexual health clinics and the online self-sampling service via the national contracts with Preventx. There is a successful pilot testing project in secondary care and substance misuse providers routinely test for HIV. Respondents were hopeful that the STP 'direction of travel' might include more work on sexual health and consideration of HIV within the long-term conditions workstream.

COMMENTS

STP-related work in Northamptonshire is still developing. However, the STP plan is one of the rare examples of HIV testing content being included as a result of poor performance against the late diagnosis Public Health Outcomes Indicator. The Public Health team were part of the STP team that wrote the STP plan and identified this HIV-related need. It raises the question as to why hardly any other STP plans covering areas of worse than benchmarked late HIV diagnosis mention HIV testing.

It is clear that there are other areas of collaboration around HIV beyond the mention in the STP plan, for example progress on an integrated sexual health and HIV service. We were told that the STP had the potential to provide an alternative level for governance around quality assurance across sexual health and HIV in the STP area. We look forward to hearing of further engagement with STP processes locally as a way to develop the quality of HIV and sexual health services. There needs to be particular attention to how the voices of people living with and affected by HIV can be heard in the absence of strong local voluntary and community sector organisations.

We note with concern the recent news of the financial difficulties faced by Northamptonshire council. We trust this will not adversely affect the important initiatives described in this briefing.

WEST YORKSHIRE AND HARROGATE

HIV STATISTICS FOR WEST YORKSHIRE AND HARROGATE

The West Yorkshire and Harrogate STP covers eight local authorities - Bradford, Calderdale, Craven, Harrogate, Kirklees, Leeds, North Yorkshire and Wakefield. Leeds is the only high prevalence area with a prevalence rate of 2.59.⁷⁸ The rest range from 0.69 in North Yorkshire to 1.37 in Kirklees.⁷⁹ Late diagnosis rates in the area are lowest in Craven at only 12.5%, mainly due to only one person being diagnosed late between 2014-2016 in the area.⁸⁰ The highest late diagnosis rate was in Bradford (50.9%).⁸¹

The STP also covers eleven CCGs: Airedale, Wharfedale and Craven; Bradford City; Bradford Districts; Calderdale; Greater Huddersfield; Harrogate and Rural Districts; Leeds North; Leeds South and East; Leeds West; North Kirklees; Wakefield.

HIV IN THE STP

There is mention in the STP plan in the section on specialised commissioning that the West Yorkshire and Harrogate Specialised Services Steering group has started work on HIV in 2016/17, to 'review arrangements to ensure resilience and sustainability of HIV provision and improve patient access'.⁸² More background to this reference was provided by NHS England's specialised commissioning team. HIV services within the STP area have been a focus for specialised commissioning over the last few years following Mid Yorkshire Hospital NHS Trust giving notice to commissioners on the provision of the service. A new service provider (Leeds Teaching Hospital

NHS Trust) was identified through a procurement process which included significant stakeholder involvement.

STAKEHOLDER ENGAGEMENT

There was a consensus amongst clinicians that this reference to HIV in the STP came about because of the disruption to HIV services which has resulted from sexual health service tendering. There had not been any direct engagement around the STP specifically with local HIV clinicians and they were not aware of any current initiatives or developments at STP level. Similarly, voluntary sector organisations had not been consulted in the development of the STP and they agreed with clinicians on the reason for HIV inclusion being the experience of sexual health tendering.

CURRENT STP PLANNING AROUND HIV

This is not to say that no engagement has taken place around service redesign. The NHS England specialised commissioning team and clinicians emphasised, for example, that there had been engagement with clinicians, the voluntary sector and patients in relation to the procurement of a new HIV service, an engagement which continues. Furthermore, we were told that the Yorkshire and Humber clinical network were planning a MONHICA event in July 2018 where one of the two topics for discussion is to be 'HIV service engagement with STPs'. There is ongoing commitment from NHS England specialised commissioning teams to work with services and partners to ensure HIV services can feed into wider discussions as plans develop.

COMMENTS

This is another example of an STP where despite there being a brief mention of HIV in the plan, there does not seem to have been much if any substantive engagement with local HIV stakeholders in the plan's development. The issue of the impact of local authority sexual health service procurement on HIV services has been a vexed one across the country and the mention of this issue in the STP is very welcome. It is less clear whether or how STP processes themselves will make any difference to this activity beyond the collaboration which has in any event taken place to date. We look forward to hearing of any progress and benefits from this approach, and for outcomes from the planned discussion on 'HIV service engagement with the STP'.

It is worth noting that the STP plan includes a 'target for change' of 'Supported self-care for all people with a long-term condition, with peer support and access to technology designed for your needs'. Whilst HIV is not specifically mentioned, this is clearly an opportunity to ensure all people with HIV in the STP area have ready access to high quality peer support and other long-term condition services. There do seem already to be a good range of support services in this STP area but local stakeholders may want to consider any further development potential – the Brunswick Centre, for example, gave us a number of areas for further attention. It is one example (and all the STP plans discussed in this briefing have such examples) of generic content in the plan which can be drawn on by the local HIV sector to make the case for service development through system-wide integration.

We note that West Yorkshire and Harrogate STP has been selected for development of an integrated care system.

HIV AND LOCAL APPROACHES

LONDON

– A FAST-TRACK CITY

In January 2018 London joined the Fast-Track Cities (FTC) Initiative.⁸³ This global initiative is supported by UNAIDS, IAPAC, UN-Habitat and the City of Paris, and aims to get cities around the world signed up to achieve the UNAIDS 90-90-90 targets as well as zero HIV stigma and discrimination. The four London signatories to the FTC Initiative are the Mayor of London, London Councils, NHS England and Public Health England.⁸⁴

London has in fact already achieved the 90-90-90 targets for the overall population of people living with HIV.⁸⁵ In addition to committing to make further progress against these measures, and achieving zero stigma and discrimination, the four partners have committed to working to end all new HIV infections by 2030 (a UN Sustainable Development Goal), to stop preventable deaths from HIV causes, and to work to improve the health, well-being and quality of life of people living with HIV across the capital.

This is an exciting step in collaboration focussed on HIV, in a city with an especially fractured political economy (the Mayor and Greater London Authority, as well as 33 London local authorities of varying political colours). The obvious question is how this welcome initiative will sit alongside health and care system collaboration within the STP process. STPs include key partners to the FTC initiative, but also and in addition CCGs and key providers, who are essential stakeholders in improving both HIV testing and long-term condition support for people living with HIV.

In addition to STPs bringing in more partners around the goals of the FTC initiative, we hope the FTC initiative will also result in some greater consistency in STP focus on HIV across London. It is striking and worrying that with all London councils having high HIV prevalence of over two diagnosed with HIV per 1,000 population,⁸⁶ we can have one STP which does not mention HIV at all in its plan, a couple which appear to be pressing forward proactively with work both on HIV testing and long-term condition support, and others which seem to limit their HIV attention to costs control or the pre-existing London Sexual Health Transformation Programme.

Both STPs and the FTC initiative are in the early stages of development, but it will be essential that they work in synergy, to their respective strengths, and to a common purpose in relation to HIV, rather than tripping over each other. STPs may have potential to be key partnerships in securing London's ambitions as a Fast-Track City.

As this briefing paper was being finalised, Greater Manchester announced it is also joining the Fast-Track Cities initiative.

GREATER MANCHESTER

HIV STATISTICS FOR GREATER MANCHESTER

The Greater Manchester area has a population of 2.8 million and covers ten local authorities (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, Wigan) and ten CCGs (Bolton, Bury, Heywood, Middleton and Rochdale, Manchester, Oldham, Salford, Stockport, Tameside and Glossop, Trafford, Wigan).

PART TWO



HIV AND LOCAL APPROACHES



Three out of the ten local authorities have a high HIV prevalence rate, Manchester, Salford and Rochdale.⁸⁷ Manchester has the highest rate (6.45 per 1,000), while the lowest in the STP area is Wigan (1.2 per 1,000).⁸⁸ Late diagnosis ranges from a low of 39.1% in Bury to the very high 74.1% in Wigan.⁸⁹

HIV AND THE GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP (GMHSCP)

In Greater Manchester we see a different model from the STP approach otherwise discussed in this briefing paper. Greater Manchester is one of the first areas of the country to implement the devolution model, in which the health and social care budget for the region is devolved, and the first to implement the integrated care system outlined by the NHS in its March 2017 document 'Next Steps on the NHS Five Year Forward View'.⁹⁰ These integrated care systems are 'evolved' or 'advanced' forms of STPs in which 'commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations'.⁹¹ They will take more control of funding and performance with less involvement by national bodies and regulators, taking the lead in planning and commissioning care for their populations and providing system leadership.⁹²

The GMHSCP is the body charged with implementing devolution and the integrated care system in Greater Manchester, with 'system leadership', and is a partnership of the ten local



GREATER MANCHESTER'S POPULATION HEALTH PLAN HAS COMMITTED TO A VISION OF ENDING ALL NEW HIV TRANSMISSIONS WITHIN A GENERATION.

authorities and ten CCGs plus the 13 local NHS Trusts and NHS Foundation Trusts.

Greater Manchester's Population Health Plan has committed to a vision of ending all new HIV transmissions within a generation. To that end, the GMHSCP has agreed a workstream and will provide £1.3 million of additional 'pump priming' funding over the next two and a half years. The 'mobilisation' stage is now underway and will involve procurement of an organisation to coordinate the work. There will also be 'tweaking' of existing contracts with providers. There will be an emphasis on HIV testing in the programme, and community testing, early diagnosis and prompt treatment in particular. The budget holder for the new programme is Oldham CCG but this is purely for financial accountability purposes. Governance will be based in the Sexual Health Strategic Partnership Board, which reports in

to the Population Health Plan Board, part of the GMHSCP.

STAKEHOLDER ENGAGEMENT

There is clearly a great benefit to a single public vision for the elimination of HIV across the whole Greater Manchester region. How did this success come about? Talking to local stakeholders a number of lessons emerge.

First, **regional collaboration pre-dated the devolution model, and was the basis for successful development of a public health programme on HIV.** The Greater Manchester Sexual Health Network has been active and effective since 2003, supporting discussion, coordination and collaboration.⁹³

Secondly, **effective consultation with stakeholders within the HIV sector was vital to a successful proposal.** Once HIV was included within the Population Health Plan, Rob Cookson, from the LGBT Foundation, was seconded for one day a week to the GMHSCP to lead on putting together a submission on ending all new transmissions within a generation. A workshop was held with 30-40 people – sexual health workers, GPs, the VCSE sector, public health consultants, pharmacists – with the basic question ‘what do you think of this ambition [to end all new HIV transmissions within a generation] and how should we do it?’. Three focus groups also took place with at risk communities – George House Trust held one for people living with HIV; LGBT Foundation with people from the LGBT community; and BHA for Equality held one with people from BME communities. Members of the Ending all new cases of HIV (HIVE) working group spoke with local commissioners and providers, clinicians and with people from the VCSE sector to agree interventions and to author the bid documents.

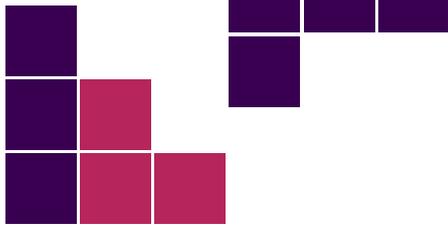
CURRENT PLANNING ACROSS GMHCP

The planning of public health at the Greater Manchester level means work can progress on identifying the best ‘level’ (GM-wide or more local) for various interventions. Common standards (e.g. service specification and cross-charging arrangements) across Greater Manchester have been developed for sexual and reproductive health. Provider networks are also coming together, for example in the PaSH partnership (HIV/STI prevention and support), which enables resources to be used more efficiently and effectively.⁹⁴ The PaSH partnership is commissioned in a single contract by the sexual health commissioner for Salford as the lead commissioner on behalf of all 10 GM local authorities. The PaSH partnership is a collaboration between George House Trust, BHA for Equality and the LGBT Foundation to meet the changing needs of those newly diagnosed with HIV, living longer term with HIV or at greatest risk of acquiring HIV.

When the GMHSCP formally took charge of the £6bn health and social care budget on 1 April 2016, it also assumed delegated responsibility for a wide range of specialised services including HIV treatment. Whilst NHS England remains legally responsible for the delivery of its statutory functions, a Memorandum of Understanding (MoU) has delegated responsibility for the operational management of these services to the GM Chief Officer. HIV service pathways are being considered in the options appraisal of Greater Manchester’s Sexual Health Strategy.

This offers the potential for greater integration of HIV clinical services with sexual health services and long-term condition support, and indeed possibly with mental health and drug and alcohol services also. Whilst the ‘specialised

PART TWO



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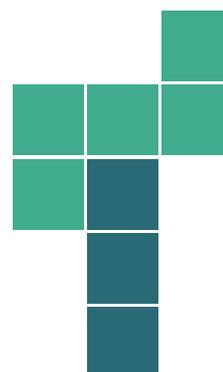
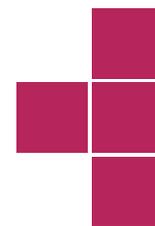
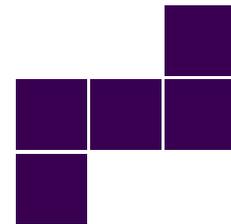


commissioning' component of HIV within the GMHSCP is at an early stage of development, we will follow progress and outcomes with interest.

COMMENTS

It appears that **devolution provided both further governance focus and funding to develop GM-wide actions to address sexual health and HIV**. The additional £1.3 million draws on additional funds made available to Greater Manchester in a £450 million Transformation Fund.⁹⁵ The Sexual Health Strategic Partnership Board is established within the new devolution governance arrangements and includes representation from lead clinicians, GPs and commissioners.

Furthermore, **the successful case for HIV being a priority and then for the particular bid for funding drew on effective arguments linking HIV to wider Greater Manchester public health ambitions**. In particular, the initial inclusion of HIV within the GM Population Health Plan was assisted by linking HIV to the concern for 'the missing thousands' i.e. those with conditions such as diabetes and cancer who are undiagnosed.⁹⁶ There was a focus from the LGBT Foundation, BHA for Equality and others on those living with HIV who are undiagnosed and the financial costs of late diagnosis. They were able to draw on both national PHE data and, later on, more specific advice from the local PHE office and a consultant to provide estimates of those undiagnosed in the GM area and the cost-effectiveness of improved testing. The HIV workstream also links in well to the focus in the Plan on prevention and on Living Well, 'where early identification and treatment for adults can have a very positive impact on quality of life, health outcomes and life expectancy'.⁹⁷



ENDNOTES

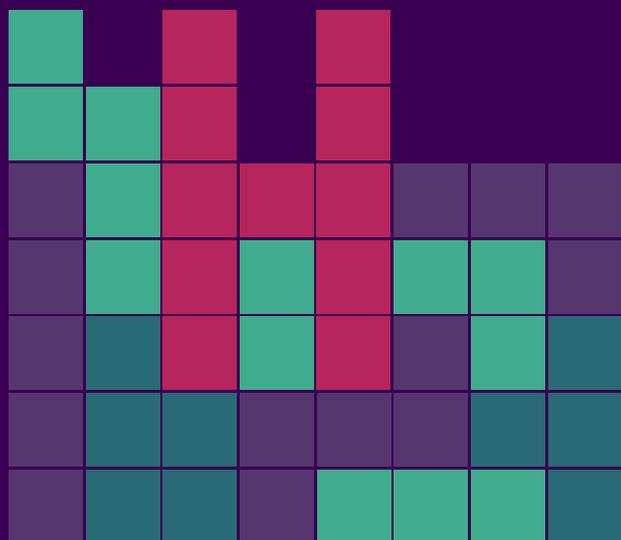
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- 70 Private Correspondence: Letter from Cambridgeshire and Peterborough STP to NAT, 2018.
- 71 Ibid.
- 72 In 2016 the STP did not include a high prevalence local authority but in 2017 PHE reported that Peterborough was a high prevalence local authority (diagnosed prevalence of 2.06/1,000)
- 73 Public Health Outcomes Framework. Op. cit.
- 74 Ibid.
- 75 Ibid.
- 76 Northamptonshire's Sustainability and Transformation Plan (STP), 2016. Op. cit. (page 40).
- 77 Ibid. (page 40).
- 78 Public Health Outcomes Framework. Op. cit.
- 79 Ibid.
- 80 Ibid.
- 81 Ibid.
- 82 West Yorkshire and Harrogate Sustainability and Transformation Plan (STP), 2016. Op. cit. (page 58).
- 83 For more information on the Fast-Track Cities Initiative, please visit: <http://www.iapac.org/cities/>
- 84 For more information, please visit: <https://www.healthylondon.org/our-work/prevention/fast-track-cities/>
- 85 Brown AE, Kirwan PD, Chau C, Khawam J, Gill ON, Delpech VC. Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK -2017 report. November 2017, Public Health England, London.
- 86 Ibid.
- 87 Public Health Outcomes Framework. Op. cit
- 88 Ibid.
- 89 Ibid.
- 90 In the document integrated care systems are called 'Accountable Care Systems'. Since the publication of 'Next Steps on the Five year Forward View' the nomenclature has been changed and we use the current terminology 'integrated care system'.
- 91 NHS England and NHS Improvement 'refreshing NHS Plans for 2018/19' Feb 2018 p.12, para.5.2
- 92 King's Fund Feb 2018 'Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England'
- 93 See for an example of previous work 'Halving late diagnosis of HIV: a toolkit for action' MEDFASH, Greater Manchester Sexual Health Network, Halve It, July 2014
- 94 PaSH is an integrated sexual health improvement programme for Greater Manchester offering targeted prevention services and HIV testing for key populations at risk of HIV and HIV support services for adults, children and young people.
- 95 For more information on the £450 million awarded to the GMHSC, please see here: https://www.greatermanchester-ca.gov.uk/news/article/35/five-year_vision_for_better_health_and_social_care_in_greater_manchester
- 96 Greater Manchester Health and Social Care Partnership 'The Greater Manchester Population Health Plan 2017-2021'. Available here: <http://www.gmhsc.org.uk/wp-content/uploads/2018/04/GM-Population-Health-Plan-Full-Plan.pdf>
- 97 GMHSC Strategic Partnership Board Report 27 Jan 2017

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