Report author: Eleanor Clark

Tel: 0113 3787844

Report seeking authority to procure a new Sexual Health Improvement Service for those populations most at risk of HIV

Date: 21st July 2021

Report of: Head of Public Health (Health Protection)

Report to: Director of Public Health

Will the decision be open for call in? ☒Yes ☐No

Does the report contain confidential or exempt information? ☐Yes ☒No

What is this report about?

Including how it contributes to the city's and council's ambitions

- In 2014 Leeds City Council commissioned HIV prevention activity with a focus on sexual health promotion activities, including group sessions, 1:1 support and peer support, condom provision and community-based HIV Point of Care testing (POCT) within most at risk populations for HIV. At present this activity is focussed on at the two cohorts that represent the largest incidence of HIV: black African communities and Men who have Sex with Men (MSM). The two contracts are due to expire on 31st March 2022.

- Approval is being sought to procure a single new service, with a wider scope to include other populations identified as being at higher risk of HIV within a broader sexual health improvement remit.

- This will support the health priorities within the Best Council Plan, namely:
    - Reducing health inequalities and improving the health of the poorest fastest
    - Supporting healthy, physically active lifestyles
    - Supporting self-care, with more people managing their own health in the community

Recommendations

a) The Director of Public Health is recommended to approve authority to proceed with a competitive procurement process, as outlined in this report and in line with Contract Procedure Rules (CPRs) 3.1.7, to procure a suitable provider/consortium to deliver a new Sexual Health Improvement Service for most at risk populations for HIV, for a period of 5 years commencing 1st April 2022 (with an option to extend for a period of up to 36 months in any combination) with a maximum budget of £276,370 per annum (£2,210,960 for the overall contract period).

b) Furthermore, the Director of Public Health is asked to note that a report will be submitted for approval at the end of the procurement process to approve the contract award, which will be a direct consequence of this key decision and will therefore be a significant operational decision at most, which will not be subject to call in.

Why is the proposal being put forward?

1 The UK is one of the first countries to meet the UNAIDS 90-90-90 targets. In 2018 Public Health England estimated that 92% of people living with HIV in the UK had been diagnosed, 98% of those diagnosed were on treatment, and 97% of those on treatment were virally suppressed. The UK Government has set out a commitment to end transmission of HIV in England by 2030.

2 Leeds is a high rate city for HIV with a diagnosis rate of 11.4 per 100k population (15-59) compared with the national average of 8.1 per 100k and a late diagnosis rate of 57.1% compared with the national average of 43.1%.

3 In 2014 Leeds City Council commissioned HIV prevention activity with a focus on sexual health promotion activities, including group sessions, 1:1 support and peer support, condom provision and community based HIV Point of Care testing (POCT) within most at risk populations for HIV.

4 A competitive procurement exercise was undertaken, with provision divided into two lots. Lot 1 was to work with black African communities, with the contract value of £114,770.00 per annum. Lot 2 was to work with MSM and the contract value was £161,600.00 per annum.

5 The contract term was 5 years with the option of four 12-month extensions available. In December 2020, approval was given to extend the contracts until March 2022. There is still one 12-month extension available, but there is a need to widen the scope of the provision to include additional approaches and communities and to recognise advances in HIV prevention and treatment over recent years which has seen new cases of HIV nationally and locally decline significantly. The availability of Pre-exposure prophylaxis (PrEP) which has been available privately and via the national IMPACT trial over the last several years and more recently via the NHS from October 2020, has had a significant impact on reducing new cases of HIV. PrEP is taken by people meeting high risk criteria who do not have HIV, to prevent HIV transmission by taking either a pill every day, or before and after a planned higher risk event. Alongside this prompt treatment for HIV+ people can reduce viral load to undetectable levels rendering the virus un-transmittable (U=U message)

6 Although significant progress has been made in terms of prevention and treatment for HIV, impact has been inequitable amongst all higher risk group with black African communities, Transgender people and vulnerable women under represented. Alongside this there are also potentially emerging new most at risk populations within the city including some newly migrated communities It is therefore considered that a new procurement exercise should be carried out within the current financial year with a view to a new contract commencing on 1st April 2022, instead of making use of the final extension period.

7 The following proposals for the new contract are based on the findings of a review including data analysis, consultation with current service users and staff, clinical staff and stakeholders, and a reflection on best practice in other Core Cities and areas. A summary is included at Appendix A.

8 The intention is to procure a single Sexual Health Improvement Service for most at risk populations for HIV (MARPs), rather than continuing with the existing model of two separate HIV prevention services. This will allow the service to be delivered in a more cohesive and collaborative way, allowing for more flexibility around target groups and accommodation of overlapping vulnerabilities and differing risks e.g. MSM from black African communities, or an LGBTQ+ person who is also an asylum seeker. This model also reduces the duplication of core costs, providing the opportunity to rationalise and achieve better value for money. It will also simplify contractual arrangements, including an individual performance and quality

framework managed by a single point of contact within the council, who can assess and evidence performance, impact, value for money and financial accountability.

9 In response to the latest prevalence data, the in-scope populations would be extended to include:

- Black African Communities
- Men that have Sex with Men (MSM)
- Transgender people
- Asylum seekers and refugees
- Newly migrated communities identified through mapping data
- Young people from in scope populations
- Other groups identified as being at higher risk via mapping data and intelligence.

The service should also establish partnerships and collaborate with key organisations commissioned to work with other most at risk populations for HIV such as sex workers, drug users, street homeless and prison populations as well as primary and secondary care providers

10 Although a clear focus on HIV prevention will remain within the specification, the remit will be widened to allow for a broader sexual health improvement service which normalises conversations around HIV and testing, within a wider context of promoting positive sexual health messages. This approach allows for more appropriate engagement opportunities with under-represented groups e.g. sexual and reproductive health sessions for black African women covering topics such as contraception, allowing for a more subtle introduction of conversations around condom use, PrEP and HIV testing.

11 The scope will also include taking on a co-ordination role within the city for HIV testing and prevention activity, actively engaging with hospital trusts, primary care providers and social support providers to establish a whole systems approach to provision and information. The service will take a lead role in supporting the city's aspiration to become a *Fast Track City*, meeting the UNAIDS 2030 targets to eradicate new cases of HIV, onward transmission and stigma.

12 Approval is being sought for a contract of 5 years plus an extension of up to 36 months (to be taken in any combination). This is because:

- it would demonstrate commitment to city health priorities and would tie into the 2030 UNAIDS triple 0 targets; 0 new cases of HIV, 0 onwards transmission, 0 HIV+ people not on effective treatment.
- this is a preventative service which reduces the burden on the wider health system, including LCC-funded provision such as the Integrated Sexual Health Service
- it provides stability to the provider and clients, and reduces disruption to service delivery and access
- continuity of partnership working arrangements can be maintained
- staff recruitment and retention will be easier as a result of longer terms of employment, greater job security and opportunities for development
- it reduces the need for both LCC and potential bidders to resource a more frequent procurement cycle.

What impact will this proposal have?

Wards Affected: All		
Have ward members been consulted?	☐Yes	☒No

13 The service will contribute to improving and protecting the sexual and reproductive health of residents from in-scope populations through improving:

- Knowledge and understanding of HIV
- Knowledge and understanding of STIs / Blood Borne Viruses (BBVs)
- Knowledge and understanding of contraception
- Awareness of the risks associated with unprotected sex
- Awareness of the potential harms associated with other risk-taking behaviours (e.g. alcohol and drug misuse; chemsex; etc.)
- Awareness of the importance of using condoms
- Awareness of the importance of using a reliable method of contraception
- Awareness of other preventative methods (e.g. PrEP)
- Intent to practice safer sex
- Confidence and skills to negotiate safe and consensual relationships
- Confidence and skills to practice safer sex (e.g. negotiation and condom use)
- Awareness of clinical services and clinical interventions
- Uptake of HIV testing
- Uptake of sexual health screening
- Uptake of reliable methods of contraception
- Uptake of other clinical interventions (e.g. Post-Exposure Prophylaxis (PEP), other STI and BBV screening)

14 Furthermore, it is anticipated that this work will contribute to the reduction of HIV prevalence in the city.

15 The Social Value Toolkit will be embedded within the procurement and contract management processes in order to identify and measure the additional outcomes being delivered.

16 The service will address health inequalities amongst specific communities.

17 An Equality Diversity Cohesion Integration screening has been completed and is attached. There are no issues to be addressed.

What consultation and engagement has taken place?

18 As is best practice, service users and staff from the current services, as well as stakeholders including clinicians, have been consulted as part of the review. The changes to the delivery model have taken this feedback into account. A summary is included in Appendix A.

19 The Executive Member for Public Health and Healthy Lifestyles was consulted on the proposals on 8th July and was supportive.

20 Public Health Programme Board has also given its support to this approach.

What are the resource implications?

21 It is requested that the maximum amount allocated for the contract be £276,370 per annum in order to meet the identified need. This is the combined value of the current contracts. It is anticipated that some efficiencies will be realised through merging the services and the rationalisation of overheads, and potentially through the use of price / quality separated

approach of evaluation. It is not proposed that the budget be reduced any further than that, since we have identified that there are additional needs that should be met, so we will be asking the provider to do more, meaning that seeking further efficiencies would affect the deliverability of the contract. Maintaining the current budget would represent better value for money than at present as the specification will require working with a larger group of people delivering a wider portfolio of work. Furthermore, there have been no inflationary uplifts to this service for more than seven years.

22 The total contract value would therefore be a maximum of £276,370 per annum, subject to the price of the successful tender. Bidders will be invited to submit a tender within a stated budget envelope, thereby offering the opportunity for realising a saving on the current cost. There is provision within the Public Health revenue budget for this.

23 It is recognised that the council is in a challenging financial position. However, as a high prevalence area for HIV, it is important that HIV prevention, early detection and the reduction of onward transmission remain key Public Health priorities. Furthermore, the contract would be awarded on the basis that efficiencies may be required in future, which would be the subject of a contract variation, and would include standard break clauses.

24 The new service will continue to be closely contract managed to ensure robust performance monitoring takes place and value for money is being achieved for the Council.

What are the legal implications?

25 This is a Key Decision since the total value of the contract (including potential extensions) is £2,210,960 and is therefore subject to Call In. It was published on the List of Forthcoming Key Decisions on 21st May 2021.

26 This report does not contain any exempt or confidential information under the Access to Information Rules.

27 The total contract value over the eight years including the possible extensions will exceed the procurement threshold for Health and Social Care which stands at £663,540. Whilst the service is not subject to the “full” regulations but to the “Light-Touch Rules Regime” under the regulations, there is still a requirement to advertise this opportunity via the council’s YORtender portal and the Find a Tender Service to ensure an open competitive tendering exercise.

28 There is minimal risk of challenge, since the proposed approach is to award this contract through an open and competitive procurement process.

29 Subsequent decisions arising from this report, for example the decision to award the contract, will be treated as a consequence of this Key decision and will therefore be treated as a significant operational decision at most, which will not be subject to call in.

What are the key risks and how are they being managed?

30 A small project team comprising of Public Health, Adults & Health Integrated Commissioning and Procurement & Commercial Services has been set up to oversee the re-commissioning process and ensure that the process adheres to the Public Contracts Regulations 2015, as well as the council's Contract Procedure Rules.

31 A risk register has been established as part of the re-procurement process and this will continue to be managed and updated. Significant risks will be reported to the Public Health Programme Board.

32 A mobilisation period has been built into the procurement timetable to ensure that the service can be fully mobilised before the contract start date

33 This procurement will enable a continuity of provision that addresses a key public health priority and responds to changing need. The risks are the same as with any procurement, such as TUPE, the potential loss of existing experienced, skilled and trusted staff members and a transition period in which the service has to build trust, confidence and reputation amongst in-scope populations. This will be managed through the Project Team throughout the procurement and mobilisation process, and then through robust a contract management process.

34 If this decision is not approved, the current services will fall out of contract on 31st March 2022 causing significant risk to the Council and its providers. There is an evidenced need for these services and should they not continue to be delivered beyond the expiry of the current contract, this would significantly affect the Council's ability to address HIV transmission in the city.

35 Requirements relating to information governance and the processing of personal data will be included in the specification and monitored through contract management processes including a Quality Management Framework.

Does this proposal support the council's 3 Key Pillars?

☐Inclusive Growth ☒Health and Wellbeing ☒Climate Emergency

36 This service will contribute to Best Council Plan's health priorities, namely:

- Reducing health inequalities and improve the health of the poorest fastest
- Supporting healthy, physically active lifestyles
- Supporting self-care, with more people managing their own health in the community

37 Furthermore, it will support the Leeds Health and Wellbeing Strategy priority of "A stronger focus on prevention".

38 The service will operate from a number of sites to ensure easy access for service users, and therefore minimising the need to travel and encouraging the use of public transport. This helps to reduce carbon emissions and environmental pollution which contributes to city actions to better manage air quality.

39 The type of interventions provided are aimed at improving health and well-being, including the prevention of hospital admissions which helps ensure we better manage our use of resource intensive (and high footprint) health and care services.

40 The service specification will require that the service undertakes to meet all legislation, guidance and good industry practice in environmental management and the objectives of the Council's sustainability policies. Officers from Adults and Health work with the provider through the established contract management process to ensure the service is proactively seeking to minimise its carbon footprint and thereby support the Council in achieving its ambition to be carbon neutral by 2030.

Options, timescales and measuring success

a) What other options were considered?

41 The option of making use of the final extension available on the contract was considered. It is felt that, given the additional needs identified, it would be preferable to commence with the

re-procurement and establishment of a service with a broader remit as soon as possible, in order to better help address HIV transmission rates in the city.

42 There was not felt to be any justification for keeping the current model of separate services for different client groups, particularly given the need to widen the scope. An integrated approach will provide greater flexibility in delivery, as well as realising efficiencies in running costs.

43 There is also the option of ending the provision once the current contracts expire. However, given the relatively high rate of HIV transmission within Leeds, there is still a need to be met.

b) How will success be measured?

44 The contract will include a Performance Framework for the purpose of monitoring service delivery and outcomes. This will reflect the aims listed in paragraph 13 above.

c) What is the timetable for implementation?

45 If approval is given, the intention is to go out to tender in August 2021. Approval to award the contract will be sought in early December 2021, which will allow for a mobilisation period before the new contract starts in April 2022.

Appendices

46 Appendix A: Summary of Review Findings

47 Appendix B: Equality Diversity Cohesion Integration Impact Screening

Background papers

- None.

Appendix A

HIV Prevention Service Review 2021 – Summary of Findings

Data Analysis

HIV prevalence rates of between 2 and 5/1000 population (15-59s) are considered high (PHE, 2021). Leeds has a diagnosed prevalence rate of 2.77/1000, higher than the England average of 2.4/1000 and has shown a 10% increase in prevalence in the 5 years since 2014. There are areas of the city where prevalence is higher than the Leeds average: 23 out of 103 MSOAs have rates of >4/1000, 12 MSOAs have rates >6/1000. National data shows a clear correlation between areas of highest deprivation and higher HIV prevalence rates, which is reflected in the Leeds data.

New HIV diagnoses in Leeds are declining however. Annual numbers have decreased since 2018. The reasons for this are multi-faceted and include an increased availability and access to PrEP, a high proportion of people living with HIV being on effective treatment and as a result are virally suppressed, so unable to transmit the virus (Undetectable = Untransmittable) and an increased focus on opportunistic HIV testing within the city via A&E and also primary care. The majority of those newly diagnosed are White British or Black African, but diagnoses in these groups have begun to steadily decline, both nationally and in Leeds. There are smaller, but increasing numbers of diagnoses in Asian males and White groups (other). The most common exposure route for newly diagnosed people is via sexual contact within heterosexuals, followed by men who have sex with men, with new diagnoses in the latter group steadily declining since 2017 in both national and local figures. However, men are still more likely represent new cases of HIV diagnosis than women.

Late diagnosis of HIV is the most important predictor of HIV-related morbidity and mortality and an essential tool to evaluate the success of local HIV testing efforts (PHE, 2021). In Leeds, the percentage of HIV diagnoses made at a late stage of infection in 2017-19 was 57.1%, worse than the 43.1% across England. Late diagnosis indirectly informs our understanding of the proportion of HIV infections undiagnosed in the city. Figures from HIV testing services within Leeds hospital acute medical units (AMU) and emergency departments (ED) show the continued importance of opportunistic testing to seek out undiagnosed infections in those who may not present at other services. From October 2018 to January 2021 these services had 50 positive results, alongside 3 positive partners (numbers are likely to have been higher, had the ED service not paused due to COVID 19).

Consultation

Consultation took place with staff from both of the current service providers (MESMAC and BHA Skyline); HIV Consultants; key stakeholders including community and faith leaders and service users from both MESMAC and BHA Skyline (including MSM, women living with HIV and black African men and women). The key points raised were:

- *Service Users*
  - Many service users report stigma, fear and lack of knowledge of HIV and PrEP amongst a range of professionals (e.g. housing staff, dentists, GPs).
  - Outreach work is important to reach those that may not engage with targeted media or support offer, e.g. closeted MSM, minority ethnic groups. Some people fear knowing their status so need lots of support to test.
  - Information needs to be shared by trusted sources (e.g. community leaders, peers).
  - An integrated model of support was generally acceptable, although service users strongly stated the need to feel staff/workers understand their situation, have some commonality. Maintaining skills to work with specific communities must be protected amongst the workforce.

- Widening the remit of providers away from narrow target groups can remove the misconception that HIV is only a risk to particular communities.
- Work should be broadened to sexual health rather than just HIV prevention to encourage the view that HIV testing is a normal part of looking after your sexual and mental health – part of holistic self-care.
- Mixed views on online testing offer – some feel the convenience and anonymity is key, others want the reassurance and support from a worker during and after the test. Sensitive pre-test discussion is important as is emotional and practical support afterwards.
- Confidentiality is important, some fear being seen at public testing venues
- There is a lack of information and trust around PrEP in wider society – particularly amongst black African communities and bisexual men, whereas gay men tend to be more informed.
- Needs to be a city-centre venue for accessibility, need to take travel and mobility issues into account.

- *Staff from current service providers*
  - Need to maintain outreach element of the service - it's an important way of contacting vulnerable groups that don't access services and to work with people/communities where they feel most comfortable or safe.
  - Would like to see flexibility in the new contract to allow responding to emerging need/trends in a locality, rather than only a narrow focus on particular communities or risk factors – should reach harder to engage people and diverse communities that may fall between gaps.
  - Can see the benefit of offering a broader sexual health remit. Offering a range of sexual health support, information and testing, perhaps alongside other screening/support services will make services more acceptable if less HIV-focussed – more of a MECC approach.
  - It should maintain a networking element – staff can see benefits to a provider leading on a city-wide network or forum around HIV testing/awareness raising/staff training – particularly with primary care, key third sector stakeholders and community leaders. Helps to challenge stigma, reduce missed testing opportunities, and increase awareness of PrEP offer.
  - Online presence/outreach is important to reach those that prefer anonymity and those that do not tend to access services.
  - Continuation of online/remote options for testing should continue and expand, alongside the face-to-face, community testing plus offer of assisted/supported self-testing.
  - Would like to explore the possibility of offering PrEP in the community, to reduce the medicalised message around the drug and reduce barriers to access.
  - Alongside flexibility to broaden the scope of the contract, an element of specialism amongst staff in working with key Most At Risk Populations (MARPs), e.g. MSM and black African communities, should still be protected.

- *Clinical Staff*
  - Offer of combined HIV/syphilis POCT testing should be explored. Although tests may have accuracy issues, should use community testing opportunities when they arise. Supportive of continuation of offer of 3-site testing in community to improve access for MSM.
  - Groups that may not self-identify for testing but need access are trans / non-binary people and heterosexual-identifying MSM people as well as minority ethnic groups.
  - Support the provider to take a lead on an HIV testing forum, bringing together partners to share expertise and data – can see particular benefits to working with primary care and

pharmacy workforce to increase knowledge of clinical indicators and to challenge stigma. Need a whole system approach to testing in the city.

- *Stakeholders*
  - Training and awareness around HIV is key, as stigma around testing is still a challenge. Many people have had poor experiences regarding HIV in their home countries. For some there is lack of knowledge of treatment, fear of catching HIV, lack of knowledge of transmission routes. People feel more comfortable discussing issues in a relaxed environment and hearing messages from trusted sources, as sex is a taboo subject for many.
  - Need to frame HIV and sexual health within general health and offer testing amongst a wider package of healthcare to increase acceptability.
  - Reassurance around confidentiality is key to building trust in communities.
  - Online offer of testing is important for many, but difficult to access for some.
  - The contract needs to maintain and expand training element to challenge stigmatising behaviour amongst health workforce, to further upskill key community leaders to share trusted messages and to empower community members themselves so they can share knowledge with friends, family and children.

Best Practice

A comprehensive review of HIV prevention contracts and service delivery has been conducted across all of the core cities; Birmingham, Greater Manchester, Bristol, Liverpool, Sheffield, Nottingham and Newcastle resulting in the following observations and conclusions:

- There is not a consistent approach for the delivery of HIV prevention activity/contracts; some areas commission services with a specific HIV prevention focus (as in Leeds), although none of the other core cities commission separate provision for different MARPS. Other areas have incorporated community based HIV prevention activity within their HIV Social care contracts or within a level 3 clinical contract.
- HIV prevention should be delivered within the wider context of sexual health promotion and prevention.
- Services should provide a variety of options to test for HIV including point of care testing and remote home sampling options. Testing should be available via booked appointments within a community setting, made available as part of outreach as well as via home sampling kits.
- Free condom and lubricant provision should be available to vulnerable populations via postal schemes and via targeted locations including MSM scene pubs & clubs, sex on premises venues, public sex environments, community shops, hairdressers/ barbers.
- Although the use of digital technology and social media platforms are valuable tools in terms of service user engagement and communication, an equal emphasis should also be placed on the production of information that can be used at a vernacular community based level.
- Advice, support and testing should be available via a range of community based settings including sex on premises venues, public sex environments, community buildings and faith establishments (where appropriate).
- Staff should be highly skilled in appropriate engagement techniques that take in to consideration an individual's gender identity, sexual orientation, culture and faith.
- The provision of training and education is vital in increasing awareness and reducing stigma. Training should be tailored to both in scope communities as well as frontline workers such as

staff within primary and secondary care, local authority support services and third sector organisations.

- It was also noted the commitment to HIV prevention via commissioning opportunities in Leeds far surpassed the majority of other core cities. Leeds is seen by many other local authorities as an exemplar for good practice in relation to commissioned HIV prevention activity.