



## Barnet Scrutiny Committee Report 8 February 2016

<b>Title</b>	<b>London Sexual Health Transformation Project</b>
<b>Report of</b>	Andrew Howe, Director of Public Health
<b>Wards</b>	All
<b>Status</b>	Public
<b>Urgent</b>	No
<b>Key</b>	No
<b>Enclosures</b>	Appendix 1: Definitions, Commissioning responsibility, Glossary of Terms
<b>Officer Contact Details</b>	Audrey Salmon, Head of Public Health Commissioning – <a href="mailto:Audrey.salmon@harrow.gov.uk">Audrey.salmon@harrow.gov.uk</a>

### Summary

This report provides an update on the collaboration between London boroughs on Genitourinary Medicine (GUM) services and sets out the main findings of the market engagement developed by the pan London Sexual Health Transformation Project. It also sets out the next steps of the project consisting of a collaborative procurement plan for GUM services and Contraception and Sexual Health Service (CaSH) Services.

### Recommendations

1. That the Committee note Barnet and Harrow Joint Public Health Service's plans to participate in:
  - a. A pan-London procurement for a web-based system to include a 'front-end' portal, joined up partner notification and home/self-sampling

The North Central London (NCL) sub-regional arrangements, with the London Boroughs of Camden, Islington, Haringey, Enfield, Hackney and City of London, for

**the procurement of Genitourinary Medicine (GUM) and Contraception and Sexual Health Service (CaSH) Services (including primary care sexual health services, outreach and prevention).**

## **1 WHY THIS REPORT IS NEEDED**

### **1.1 Background**

- 1.1.1 This report sets out how the Council will fulfil its obligation to commission Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) and details the steps that will be undertaken to re-model services in collaboration with other London boroughs. It will also provide an update on progress undertaken to date to ensure that a new service model will be in place by April 2017.
- 1.1.2 Commissioning responsibilities for HIV, sexual and reproductive health have undergone major changes since April 2013 and are now shared between NHS England, Local Authorities and Clinical Commissioning Groups (CCGs).
- 1.1.3 Local authorities are responsible for commissioning 'open access' services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). They are also responsible for the provision of specialist services, which includes young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies.
- 1.1.4 Public Health England records (GUMCAD) show that in 2013 there were 21,091 attendances in GUM Services from Barnet residents across England. Most of these services were accessed through the Royal Free Hospital Trust either through Marlborough Clinic (at the main site in Camden) or Claire Simpson Clinic (in LB Barnet). The Claire Simpson Clinic also offers two sexual health clinics at Barnet General Hospital and Edgware Community Hospital. A Young Person's Sexual Health Outreach Service also offers testing, contraception, advice and support.
- 1.1.5 In addition, the main Contraception and Sexual Health (CASH) service is delivered by Central London Health Care Community Trust in Barnet. This service, which is comprised of contraception and STI screening and testing, is delivered at 4 locations: Edgware Community Hospital, Vale Drive Primary Care Centre, Grahame Park Health Care Centre and Torrington Park Health Centre. In 2014/15 Barnet residents attended 10031 appointments in this service.

- 1.1.6 The main CASH service is complemented with a primary care offer which is accessible through General Practitioners (GPs) and Pharmacies. In 2014/15 GPs delivered 937 appointments relating to contraceptive implants and Intrauterine Contraceptive Device (IUCD) (also known as the Coil). GPs were also commissioned to carry out chlamydia screening, of which 227 were carried in 2014. . Pharmacies are commissioned to carry out Emergency Hormonal Contraception (EHC); 105 EHC were dispensed in 2013/14.
- 1.1.7 It should be noted that as part of the Inter Authority Agreement between Barnet and Harrow Council, the monitoring and procurement of Public Health contracts for both boroughs are undertaken by the Harrow & Barnet Joint Public Health Service (H&BJPHS) with the support of Harrow Council, as the host authority.
- 1.1.8 Therefore, in line with Harrow Council's Corporate Procurement Rules (CPRs), H&BJPHS sought approval from Cabinet (November 2014) to:
- extend the Contraception and Sexual Health Service (CaSH) contracts until March 2017
  - participate in collaborative procurements, where appropriate and repeat the negotiation and direct award of Genitourinary Medicine contracts for 2015/2016 and 2016/2017.
- 1.1.9 As these contracts are due to expire in March 2017, Harrow & Barnet JPHS acquired permission from Harrow Council on 10 December 2015, as the host authority, to procure new services and to enter any collaborative arrangements with other London boroughs, for both boroughs.

## **1.2 Proposed changes**

- 1.2.1 Local Authorities (LAs) are facing unprecedented challenges in providing improved quality of service provision whilst at the same time dealing with increased demand and a backdrop of reduced funding. Members will be that an in-year grant reduction of approximately 6.2% (£1.048m) on the public health grant reduction was confirmed at the end of November and the Comprehensive Spending Review announced average real time savings of 3.9% to 2020/21.
- 1.2.2 GUM services are provided on an 'open access' basis which means that residents are entitled to visit sexual health facilities available, in any part of the country, without the need for a referral from GP or other health professionals. This open access requirement service puts the Council under financial uncertainty as the level of activity is unpredictable.

- 1.2.3 H&BJPHS are currently leading the pan London Sexual Transformation project, which aims to deliver a new collaborative commissioning model for GUM services across the capital. The key outcomes are to improve patient experience, improve sexual health outcomes and provide successful cost effective delivery of excellent services across the capital. The aim is to commission the services so that the system is operating under new contracts by April 2017.
- 1.2.4 The pan London Sexual Health Transformation project was initiated in June 2014. The project evolved from work that had been undertaken by the West London Alliance (WLA) and Tri-borough councils in 2013/14 to agree prices and terms and conditions for GUM services with the major NHS providers in North West London. In 14/15 the work expanded to include Camden, Islington and Haringey. The 12 councils working together were successful in negotiating acceptable tariff prices for GUM and in implementing standard service specifications and common Key Performance Indicators (KPIs). By taking this joint approach to discussions with GUM providers, participating councils achieved an avoided cost of £2.6m (9.1%) in 13/14 and avoided cost of £2.5m (6.5%) in 14/15.
- 1.2.5 The 12 councils agreed to jointly review the need for and provision of GUM services and recognising the interdependencies across borough boundaries, invited all other councils in London to be involved. The final group of councils who engaged in this review and contributed to project costs are: Barnet, Brent, Camden, City of London, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Islington, Kensington and Chelsea, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Tower Hamlets, Waltham Forest, Wandsworth and Westminster. London Boroughs spent approximately £101.7m on GUM services in 13/14. The 22 councils involved in this project account for 83% of this spend and clinics operating in the areas covered by those 20 councils were responsible for delivering approximately 79.1% of all the GU activity for London in 2013/14. There are now 29 councils participating in this project.
- 1.2.6 To assess the current state of GUM services in London, the project team has undertaken a GUM needs assessment, an analysis of GUM patient flow data, interviews with commissioning and public health leads in each council involved, a review of the legal and policy environment and some exploration of the possible alternatives to the traditional service models.
- 1.2.7 From this work, the project team developed case for change which is based on five elements:
- London has the highest rates of Sexually Transmitted Infections (STI's) in England. Rates vary significantly throughout London but even the London boroughs with the lowest rates of STIs are close to or exceed the England

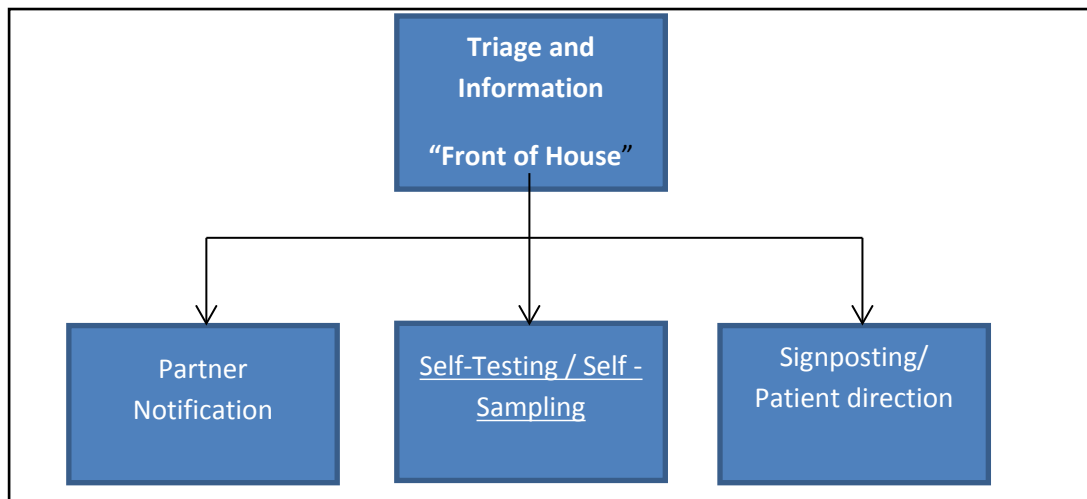
average. Men who have sex with men (MSM) and Black Caribbean communities have significantly higher rates of STI's than other groups

- Access to services is highly variable across London and significant numbers of residents from every London borough are accessing services in central London
- There is a significant imbalance in the commissioner/provider relationship. Service development has typically been provider-led. With several services in the London area, no single council has sufficient leverage to deliver significant system-level change
- The systems for clinical governance need improvement. Patient flows and the lack of a 'helicopter view' of what is taking place within individual services make it difficult for councils to have sufficient assurance over quality and safety
- Growth in demand for these services and costs of healthcare are likely to significantly outpace growth in the Public Health Grant. In addition the open access nature of the services means that it is difficult to control or predict demand. Participating councils have identified the need to develop models that will allow them to meet increasing need with decreasing resources and reduced funds. It is estimated that a cost saving of at least 20% to 25% is required to ensure the services are sustainable.

**1.2.8 The proposal is to develop a networked system of services either on a London-pan and sub-regional basis** - An integral component of this networked system will be a Pan -London Sexual Health On-Line portal. The front door into services will be through a web-based single platform; providing patients with information about sexual health, on-line triage, signposting to the most appropriate service for their needs and the ability to order self-sampling tests. A single database will be developed with the highest levels of confidentiality and security enabling greater understanding of the patient flows and with a focus on prevention and specialist services for those most in need. This web based platform is expected to commence by January 2017.

1.2.9 The **Pan-London Online Portal** will incorporate the following elements (see figure 1 below for graphic representation):

- Triage and Information (“Front of house”);
- Self-Testing/Self Sampling;
- Partner Notification; and
- Signposting/ Patient Direction and where possible Appointments (Booking system) (dependent on ability to interface with existing clinic systems).



**Figure 1: Scope of Pan-London Online Procurement Project**

- 1.2.10 There is an expectation that all major clinics will offer patients the opportunity to triage and self-sample on site, in addition all services will be required to ensure that results are available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered an appointment within 48 working hours or will be fast tracked if they present to a walk in service. Improved systems for identifying and notifying contacts of patients with an STI will ensure that resources are targeted at the highest need groups.
- 1.2.11 Alternatives to clinic-based services should be part of the future service model; new technologies including online services continue to inform and expand options for sexual health service delivery.
- 1.2.12 Centralisation of partner notification data along with the use of a single patient identifier system / technology to ascertain attendance at clinic of those notified of infection would support the reduction of rates of re-infection and repeat attendance.
- 1.2.13 The primary aim of this system will be to ensure that high volume, low risk and predominantly asymptomatic activity is controlled and managed where appropriate outside of higher cost clinic environments. By shifting testing of asymptomatic patients away from costly clinical environments through this model; it is estimated that considerable savings will be released. The evidence review and discussions with providers suggests that anything from 15% to 30% of activity could be redirected to lower cost service options in a staged manner. The results of the waiting room survey undertaken as part of LSHTP indicate that up to 50% of attendees do not have symptoms.
- 1.2.14 Locally, the vision is to develop and coordinate an integrated system of sexual health provision linked to a network of pan London and regional services. This will enable each Council to achieve the objectives set out in the Sexual Health Strategy and improve sexual health outcomes. A lead provider model is proposed to coordinate and manage all elements of the system including clinical, primary care, and the third sector. The whole system will be designed to ensure that evidence based practice drives changes, and resources are focused on groups with the highest risk. It is important that the new system is flexible and responsive to changes in demography and local need.
- 1.2.15 The next phase for the project is for the collaborating boroughs to proceed to the re-procurement of these services, with new contracts by April 2017.

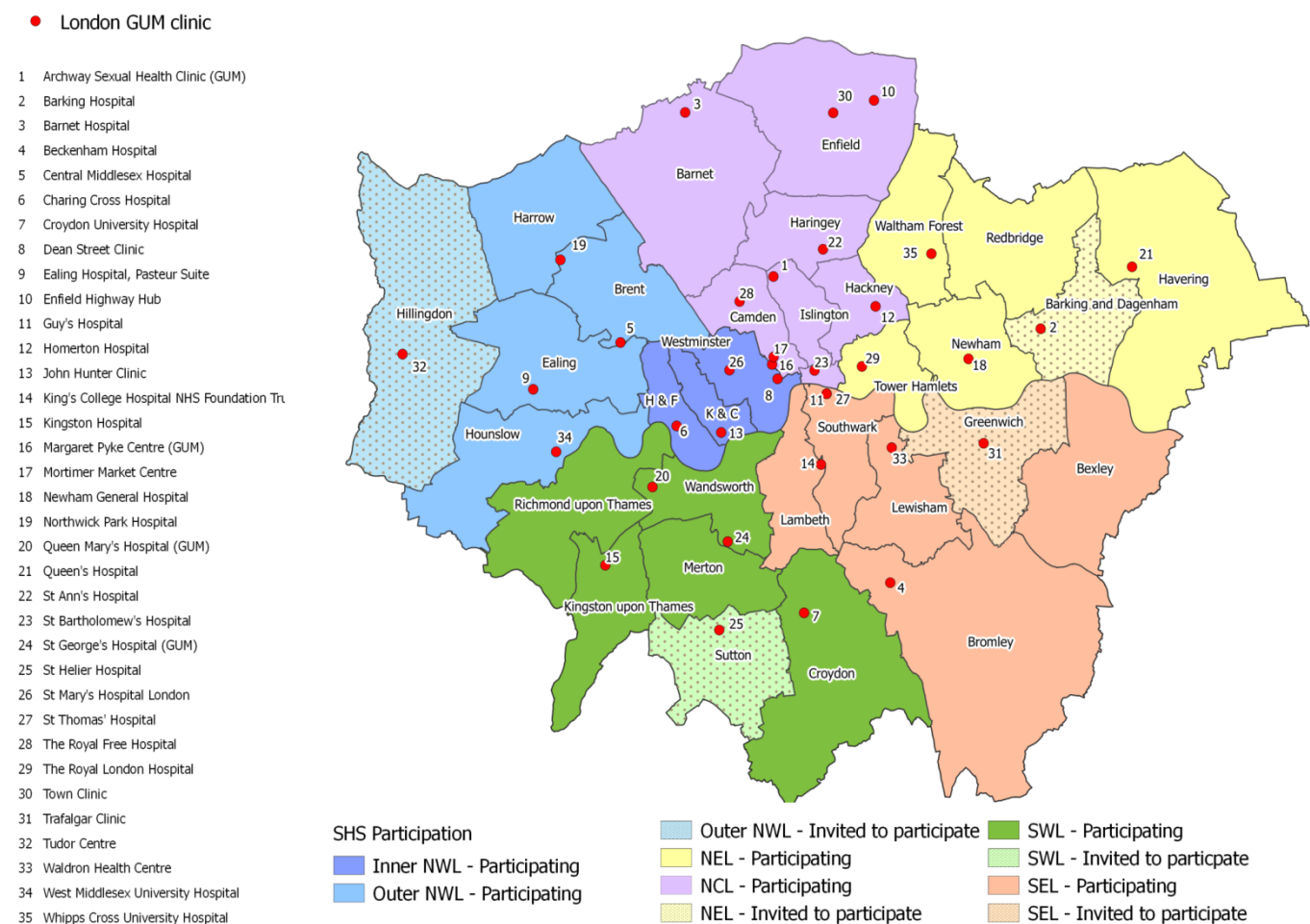
### 1.3 Sub regional procurement

- 1.3.1 GUM and CaSH services are to be procured on a geographical 'lots' basis across London. There are 2 primary reasons for this – firstly, it was identified through the market engagement exercise that no one bidder has the capability or capacity to be able to provide all sexual health services across London. It is proposed therefore to divide the London region into sub regions for the procurement of GUM and CaSH services.
- 1.3.2 Secondly considerable work has been done to map and understand how patients currently move around the system. While all boroughs will have residents who attend at almost every London service the majority of people attend services either in their borough of residence or in boroughs immediately adjacent.
- 1.3.3 This intelligence has informed the regional proposals detailed below. LB Barnet will be part of the North Central London sub-regional procurement, which will include the following Councils: Camden, Islington, Haringey, Enfield, Hackney and City of London. The sub regions are as follows:

North West London – NWL split into two sub regions NWL inner and NWL outer	
NWL outer Brent, Harrow, Ealing, NWL inner H&F, K&C, Westminster.	Hounslow, participating on the online procurement only. Hillingdon invited to participate
North Central London – NCL	
Barnet, Camden, Enfield, Haringey, Islington, Hackney and City of London.	
North East London – NEL	
Redbridge, Newham, Tower Hamlets, Waltham Forest and Havering participating on the online procurement only. B&D, invited to participate.	
South West London – SWL	
Merton, Richmond and Wandsworth. Kingston and Croydon participating on the online procurement only. Sutton invited to participate. Hounslow could opt to work in this sub region	
South East London – SEL	
Lambeth, Southwark, Lewisham, Bromley and Bexley Greenwich, invited to participate.	



## London GUM Clinics & Local Authorities participation in the Sexual Health Services review 2015



1.3.4 Barnet will collaborate with boroughs in the North Central Region for the procurement of a new integrated Sexual Health Service consisting of both GUM and CaSH service and other nonclinical sexual health services including primary care, outreach, HIV prevention for both boroughs.

1.3.5 The project will deliver a new model of clinical service delivery. The aims of the new model are to ensure that:

- Good quality services are accessible to all London residents and visitors;
- Level 3<sup>1</sup> GUM services are designed in a way that ensures they operate as part of a wider sexual health system that can meet future needs and provide excellent value for money. This will include measurably improved performance on key PH outcomes in particular prevention and early diagnosis of HIV, prevention and reductions in the incidence of STIs and unwanted teenage pregnancy.

<sup>1</sup> See Appendix 1 for definition of Levels

- iii. London councils are commissioning effectively including seeking cost effective benefits from lower transaction and operating costs for boroughs;
- iv. London councils have excellent oversight of service quality; and
- v. Service costs are reduced and that optimum quality services can be maintained in light of significant pressures on budgets

## **2 REASONS FOR RECOMMENDATIONS**

- 2.1 H&BJPHS are currently leading the pan London Sexual Transformation project, which aims to deliver a new collaborative commissioning model for GUM services across the capital. The key outcomes are to improve patient experience, improve sexual health outcomes and provide successful cost effective delivery of excellent services across the capital.
- 2.2 To engage the services to continue to be provided within a reducing financial envelope, the case for change leads to two key conclusions:
  - 1. Significant change is required to the traditional models of service delivery
  - 2. Collaboration on a wide scale across London councils is needed to deliver the level of change required and to commission these services more effectively to ensure robust quality and financial monitoring
- 2.3 It is therefore recommended for H&BJPHS to be involved in, and lead, the pan London and sub-regional developments.
- 2.4 Officers have considered a range of options to get the best price and quality for residents. Overall, the Council wants to maintain quality but with the current financial pressures, price is also critical. To achieve this, Barnet as agreed as part of the North Central Sub-region procurement at 50% quality and 50% price.
- 2.5 The project team is in the process of developing the sub criteria and evaluation methodology.

### **3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED**

#### **3.1 Alternative Option 1: Do nothing. Current system remains unchanged.**

- 3.1.1 London has the highest rates of Sexually Transmitted Infections (STI's) in England. Rates vary significantly throughout London but even the London boroughs with the lowest rates of STIs are close to or exceed the England average. Men who have sex with men (MSM) and Black Caribbean communities have significantly higher rates of STI's than other groups. See Barnet's Sexual Health Strategy for the local epidemiology.
- 3.1.2 Access to good quality GUM services is highly variable across London. Due to the nature of 'open access' GUM services, significant numbers of residents from every London borough are accessing services in central London. A Cross-charging arrangement requires local authorities to pick up the costs when local residents access GUM services elsewhere.
- 3.1.3 Costs of the services to commissioners have been managed to date by collaborative negotiations to maintain the prices at the tariff levels applied in 2012/13. In addition, the collaborating councils have achieved further containment of cost pressures by:
- Ceasing the payment of the 2.5% CQUIN that applied in the NHS
  - Negotiating efficiencies of up to 5% of tariff price
  - Agreeing marginal rates for activity above agreed thresholds.

3.1.4 However, the process involved in achieving the above has been very intensive and has absorbed a significant amount of commissioners' time; thus reducing the time available for wider commissioning activities, such as contract and performance management and longer term service planning. There is a consensus that the current model is not financially sustainable and will not deliver the efficiencies and improved outcomes required.

**3.2 Alternative Option 2: To focus on the development of a local sexual health service model that includes Level 3, reducing dependence on central London services.**

3.2.1 This localised service model would be developed on the basis that local residents could only access sexual health services within their respective boroughs. Similar to the preferred option, the local vision is to develop and coordinate an integrated system of sexual health services. However, the difference is that in this option, local services would be independent of the Pan-London on-line portal and the wider network of services provided across London.

3.2.2 As an open access service, there is an established arrangement across the Country for cross-charging, with most of the activity for both Barnet and Harrow seen in London. Due to the confidential and sensitive nature of this service, many residents choose to access GUM services outside their borough of residence; for convenience they opt for services closer to work or where they socialise. For example, in 2013, Barnet residents attended 18,231 appointments in GUM services in 2014/15; only 24% of this activity was seen at Barnet Hospital whereas 36% was seen at the Royal Free Hospital in Camden. The rest of this activity was in Islington (15%), Westminster (12%), Brent (4%), Southwark (2%), City of London (2%), Enfield (1%), Hammersmith (1%) and rest of London (4%).

3.2.3 For this model to be successful, more local residents would need to be attracted to the local service. Although we intend to encourage more residents to access sexual health services locally, we will need to accept that some residents will continue to use out of borough provision for convenience. There is evidence to show that some of the central London clinics are much more accessible and appropriate for the needs of high risk groups (particularly for men who have sex with men) and it may not be cost-effective to replicate this provision locally, particularly if residents prefer to access these services in a central location. It is worth noting that there are interdependencies between each London borough's sexual health provisions and therefore a local model would not be able to sufficiently meet the needs of all local residents.

## **4 POST DECISION IMPLEMENTATION**

4.1 As a decision is not being sought, this section is not applicable.

## **5 IMPLICATIONS OF DECISION**

## **Corporate Priorities and Performance**

- 5.1.1 The proposed new model will improve sexual health related outcomes for local residents, particularly vulnerable and high risk groups, such as Black African communities and men who have sex with men (MSM). The proposed new service model will support the core principles of the Council's Corporate Plan, of "fairness, responsibility and opportunity".
- 5.1.2 The new service will enable residents to 'further their quality of life' by improving access to high quality sexual and reproductive health services through community and primary care. The London Pan-Online portal will 'help' residents to maintain their sexual and reproductive health by preventing and protecting themselves and others from sexually transmitted diseases and unwanted pregnancies. Residents will be encouraged 'to help themselves' by using the on-line portal to: (1) access information about local sexual health service, (2) request STI self-sampling and (3) support the partner notification service.
- 5.1.3 As demonstrated through this report, the proposed new service model of sexual health services across London will deliver improved outcomes and better value for money for residents.

## **5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

- 5.2.1 In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget.
- 5.2.2 The Public Health Grant is currently ring fenced, however the Comprehensive Spending Review noted the Government intention to consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100 per cent business rate retention. The ring-fenced on public health spending will be maintained in 2016/17 and 2017/18 with average real time savings of 3.9% per annum until 2020/21.
- 5.2.3 Across London, councils currently spend approx. £115m per annum on GU services excluding contraception and this is predicted to increase to £124.5m by 2022 if LA's do not take action to redesign the system now. The financial prediction is estimated on the basis of projected population growth(which varies from Council to Council) however this may be a conservative estimate as changes in behaviour are driving demand also
- 5.2.4 The starting point for the grant for 2015/16 for Barnet totals £14.335m, excluding the in-year allocation for Health Visiting and the in-year grant reduction changes to the ACRA formula.

5.2.5 Sexual Health spend proportion of the non-HV element of the grant is 36% Barnet. The grant is a ring-fenced allocation for the provision of both mandatory and discretionary public health services. In this respect, the impact of changes in expenditure arising from the procurement exercises will need to be contained within the annual grant amount.

5.2.6 Whilst the ring-fence is maintained, any efficiencies achieved on public health expenditure (including that delivered through procurement programmes) deliver capacity in the grant. This grant capacity then enables mitigation of demand led service growth in areas such as sexual health, with any residual capacity being available to grant fund expenditure appropriately incurred across the council delivering the wider determinants of health.

As GUM and primary care activity are funded on an activity basis, the projected spend for 2015/16 is based on the previous year's spend. Barnet expenditure for all sexual health services for 2014/15 was £4.6m.

5.2.7 The current system of contracting for services where tariffs are renegotiated annually and frequently not agreed until well into the financial year is time consuming and does not allow for proper financial planning on the part of either commissioners or providers. In this current year, most Trusts have not yet reached agreement with commissioners until autumn 2015. The proposal is to award contracts for a minimum term of 5 years which will ensure that the current annual cycle of tariff negotiation is avoided and that providers can invest in any systems or premises necessary to deliver transformed services.

5.2.8 The current contracts for GUM and CaSH Services were previously extended and they will expire on 31<sup>st</sup> March 2017. Procurement will include both services.

5.2.9 The proposed initial contract term of the Sexual Health Service procurement will be 5 years, commencing 1 April 2017 to 31 March 2022; with an option to extend for up to a maximum of 4 further years (up to March 2026), subject to performance and funding availability.

5.2.10 Based on current spend the LSHTP estimated aggregate value across participating London Authorities of the proposed GUM contract for 5 years is in the region of (£498.5 million) plus 4 years (£404.7 million.) = £903.2 million. All the above figures are subject to funding.

5.2.11 The above estimates are based on:

- calendar year 2014 total attendance (first and follow activity) taken from GUMCAD2 reporting system
- The tariff agreed by commissioners for 13-14 tariff which was £133 for a first appointment and £82 for a follow up appointment and NHS Market Forces factor (MFF). The calculations do not include any deflators or application of marginal rates as these varied per Trust. The calculations do include projected change in the population of each London borough.

- The estimates include, GU activity only, they does not include block contracts for Contraception and Sexual Health (CaSH)

5.2.12 For Barnet, based on current spend the estimated aggregate value of the proposed GUM contract for 5 years is in the region of £33.9 million. All the above figures are subject to funding.

5.2.13 The current annual CaSH contract value is £930k; £65k for Primary Care and £38k HIV testing (Home Sampling).

5.2.14 It should be noted that the above estimates are based on current spend based on separate contracts and therefore are only indicative. The actual contract value will be defined following the procurement and providers are already informed that LSHTP seeks to reduce capacity within a clinic setting and integrate services with the view to improve the service offer to residents.

5.2.15 This procurement, which is part of a wider sexual health transformation project, is expected to deliver savings. The following areas are ways in way the efficiencies are expected to be achieved:

- Single web based front door to services ie; online triage which will enable self-sampling and potentially increased use of GP's and pharmacies
- Single partner notification (PN) system
- Redirection of asymptomatic patients
- Consolidation of numbers of Level 3 GUM clinics
- Economies of scale
- Use of an integrated tariff

5.2.16 The anticipated 2016-17 budget for GUM services for Barnet total £4.480m and the five year plan assumes a reduction of 10% in the costs of GUM services will be delivered from the procurement exercise and that future growth will be contained within the reduced budget.

5.2.17 It is difficult at this stage to quantify further the level of savings which may be delivered through an integrated service, however these are expected to be in the region of 10% - 25% although these could potentially increase over time as the system is embedded and behavioural changes are achieved. Further potential savings from the wider transformation project will be included in future budget proposals as these become more robust following the progress around the wider procurement exercise.

5.2.18 The award of any contracts will result in contractual obligations with the provider for services which are funded by external grant and which cannot be guaranteed in the longer term, however these are mandatory services.



### **5.3 Social Value**

- 5.3.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. The North Central London Sub regional group have assigned 5% of the award criteria to Social Values to ensure that social, environmental and economic benefits will be delivered as part of the contract.

### **5.4 Legal and Constitutional References**

- 5.4.1 Local authorities have a duty under The *Health and Social Care Act 2012* (“the Act”) to take appropriate action to improve the health of the local community. In general terms, the Act confers on local authorities the function of improving public health and gives local authorities considerable scope to determine what actions it will take in pursuit of that general function. Under in this Act, local authorities have a statutory responsibility to commission Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH).
- 5.4.2 It should be noted that as part of the Inter Authority Agreement between Barnet and Harrow Council, the monitoring and procurement of Public Health contracts for both boroughs are undertaken by the Harrow & Barnet Joint Public Health Service (H&BJPHS) with the support of Harrow Council. As the host authority, Harrow Council’s Corporate Procurement Rules (CPRs) will be followed.
- 5.4.3 The procurement exercise for the pan-London Sexual Health Transformation will be subject to the Public Contract Regulations 2015 (the “Regulations”) and the Council’s Contract Procedure Rules. The overall value of the contract for this service will exceed the applicable threshold and so it will be necessary for the tender exercise to adhere to the strict application of the Regulations.
- 5.4.4 It is proposed to use one of the new processes introduced by the Regulations that allows for negotiation throughout the tendering exercise which will ensure good quality services are procured at a competitive price.
- 5.4.5 The procurement of public health contracts are subject to the overriding EU Treaty principles of equal treatment, fairness and transparency in the award of contracts.
- 5.4.6 5.4.2 The Council’s Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

*“To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.”*

## **5.5 Risk Management**

- 5.5.1 The key risk to achievement of outcomes within timescales is the complexity of partnership working. Some changes or waivers to individual council's policies or procedures may be required due to the nature of arrangements where significant numbers of different organisations are involved. For some inner London services, up to 8 councils will need to be involved to effectively commission the services.
- 5.5.2 It is important to note that service transformation and behaviour change may require clinic redirection and alternative suitable clinical premises located at "hotspots" which may not be feasible within the procurement timescales. In addition the premises need to meet all legal and planning regulations in order to deliver core services. An example where delay may occur and affect the procurement timetable may be the need of a D1 planning status for the treatment services. Whilst the provider(s) develop their own property strategy to locate within the regions we will work with the outgoing and incoming providers to ensure that services aren't disrupted.
- 5.5.3 Due to the nature of the service, possible re-location of the new service may meet local opposition. LAs will need to work with residents, stakeholders, the local press and politicians to ensure the establishment of the new service is managed effectively. There is a project communication strategy addressing key messages and key audiences ensuring consistency of communication.
- 5.5.4 It is important that councils work closely together, any LA doing different things in their area or not delivering their part within the collaborative project will negatively impact on each other and the collaboration project.
- 5.5.5 On the basis of a collaboration across 26 councils (potentially 28) London boroughs, it is estimated that a pan-London procurement would be for services of a value between £0.5 billion for an initial 5 year contract and £1billion for the 9 year contract which included 4 years (2+2) extension. Whilst sexual health services fall under the 'light touch' regime in the Public Contract Regulations 2015 the anticipated value of the procurement sum is considerably in excess of the threshold of €750k (approximately £625k). Given also the attention that this procurement will be given it is recommended that the full OJEU process be followed to ensure that proper processes are followed throughout each stage of the procurement.

- 5.5.6 There is no established practice of consultation on the design of sexual health services provision. Commissioners have carried out provider and service user engagement via surveys, questionnaires, focus groups, stakeholder events and one to one sessions. On individual local level, each borough needs to assure itself that they have satisfied their consultation duties in this regard. There are specific statutory duties in s. 221 of the Local Government and Public Involvement in Health Act 2007 to ensure that members of the public are involved in decisions regarding (inter alia) commissioning of health services, which may involve public consultation but need not do so (and usually doesn't).
- 5.5.7 In any collaborative procurement, it is essential that clear and effective inter-borough arrangements are put in place, not only in connection with the procurement process but also in relation to the subsequent operation of the contract. An interim collaborative governance structure with representatives from all participant LAs has been agreed pending Cabinet approval. Officers will need to establish more detailed governance arrangements. Officers will need to ensure appropriate legal, financial and other relevant advice is obtained in establishing suitable governance and professional project resources meeting procurement start of February 2016. Governance arrangements will ensure there is clear accountability and liability between the councils and appropriate binding inter authority agreements. Professional services arrangements will ensure that there is consistency of approach, legal, procurement, financial and communications advice and appropriate programme and project management. This will be particularly important for carrying out a compliant CPN procedure whilst ensuring that any risk of challenge is eliminated.

## **5.6 Equalities and Diversity**

- 5.6.1 The Council has a duty under s149 of the Equality Act 2010 to have due regard to the needs of those with relevant protected characteristics such as: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation, in the provision of Public Health Services. An Equality Needs Assessment has been undertaken to assess the impact of this procurement on local residents. In conclusion, it was recognised that there was a disproportionate prevalence of sexually transmitted diseases amongst certain groups resulting in poor outcomes for these groups. It is intended that the proposed procurement will deliver better value for money whilst achieving improved outcomes for high risk and vulnerable and the whole community.

## **5.7 Consultation and Engagement**

- 5.7.1 The following information illustrates the consultation and engagement that has been undertaken locally as part of this project; however it should be noted that this is for information only as a decision is not being sought.

- 5.7.2 A service review was also undertaken in the London Borough of Barnet during the same period. Key stakeholders and local residents were invited to participate in the service review, which comprised of focus groups, interviews and surveys. To date, a series of surveys have been completed by a variety of stakeholders: service user staff (20), GPs (21), pharmacies (6), service users (147) and young people (135). Focus groups are currently been undertaken with young people, Black and Ethnic Minority males and females and Lesbian, Gay, Bisexual and Transgender (LGBT).
- 5.7.3 The service review set out to capture information on the following themes and highlights elements of the current sexual health provision that needs improvement developments. These findings along with the needs assessment will inform the new service model. The initial findings are set out below:

- **Knowledge of sexual health services**

Service users were asked to identify the various ways they accessed information about sexual health services; 56% of respondents found information about local services from their GP; other popular responses included friends (41%) and family (40%).

Initial findings from the stakeholder surveys are as follows: 47% agreed with the statement that ‘I understand the Barnet sexual health referral pathway’ and 59% believed that the “quality of Barnet sexual health service provision is high”. Stakeholders felt that prevention was not high enough on the agenda with only 44% agreeing with the statement that “there is sufficient positive sexual health promotion taking place in Barnet”.

81% of service users believed that “lack of awareness of services was a barrier to accessing services”. In contrast, 48% said that the sexual health information “they had seen was good” and 40% felt that there is adequate sexual health information in the right places. When asked where they found information about sexual and reproductive health: 56% stated the internet, followed by their GP (41%) and friends and family (40%).

Service users felt that education and awareness of sexual health is vital; 54% expressing a need for more information through schools and colleges; with 30% stating that they had received sex education when they were at school.

The majority of stakeholders agreed that education and early intervention were contributing factors to reducing teenage pregnancies and sexually transmitted infections.

- **Attitudes, motivators and barriers to accessing services**

Service users stated the key reasons for accessing sexual health services were as follows: for contraception (86%), sexual health check-

up (77%) and due to previous experience of the service (53%)

The key barriers identified by service users included: embarrassment (83%), unaware of services available (81%), opening times not convenient (73%), believe their behaviour will be judged (64%).

- **Needs and priority target groups**

Service users were asked if services should be targeted at any particular groups: 30% stated that more work should be targeted at those at risk, with 29% identifying young people as a particular target group.

Over 50% of stakeholders identified the need to target service provision at the following groups: vulnerable adults (particularly those with mental health issues and learning disabilities) and those from the following communities LGBT, BME and men who have sex with men.

- **Experience of services**

Over 80% of service users stated that they had a positive experience of existing sexual health services.

5.7.4 The local service review and need assessment highlighted the importance of health education and awareness raising with regards to the local service provision. It also identified the lack of coordination and the fragmented nature of the current service pathway. It also highlighted the need for improved access to services for vulnerable and high risk groups, particularly young people.

5.7.5 The London Sexual Health Transformation project, the Local Sexual Health Strategy and the initial findings from the service review highlight the need for a change in the way that local services are delivered in Barnet and Harrow. The next step is to re-model the service and to develop a service specification which reflects the needs and demands of the local residents, whilst considering the interdependences which exist between local provision and regional and pan-London network of services.

5.7.6 The commissioning and provision of an integrated service model is supported by professional guidance from FSRH, BASHH, BHIVA, MEDFASH, RCOG and NICE<sup>2</sup>. It is also supported by Department of Health and Public Health England.

---

<sup>2</sup> See Appendix A for Glossary of Terms

## **5.8 Insight**

- 5.8.1 The JSNA is an insight document which pulls together data from a number of sources including Public Health Outcomes Framework, GLA population projections and local analysis. The Joint HWB Strategy has used the JSNA as an evidence base to develop priorities.
- 5.8.2 The sexual health procurement will enable the Board to deliver its commitment to improve local sexual health priorities as set out in the JSNA and the Sexual Health Strategy 2015-2020. Sexual Health Strategy 2015 -2020 accepted by Health and Wellbeing Board on 13 November 2014.

## **6 BACKGROUND PAPERS**

- 6.1.1 Barnet Sexual Health Strategy 2015-2020, Health and Wellbeing Board, Thursday 13 November 2014, item 9:  
<https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7783&Ver=4>