
REPORT FOR: **CABINET**

Date of Meeting:	10 December 2015
Subject:	London Sexual Health Transformation Project
Key Decision:	Yes
Responsible Officer:	Andrew Howe – Director of Public Health
Portfolio Holder:	Councillor Varsha Parmar, Portfolio Holder for Public Health, Equality and Wellbeing Councillor Sachin Shah, Portfolio Holder for Finance and Major Contracts
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All Wards
Enclosures:	Appendix A - Definitions, Commissioning responsibility, Glossary of Terms Appendix 1 – Harrow – Sexual Health Strategy 2015 – 2020 Appendix 2 – Barnet Sexual Health Strategy 2015 – 2020 Appendix 3- Equality Impact Assessment

1. Section 1 – Summary and Recommendations

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.

1.1. Recommendations:

Cabinet is requested to:

1. Approve the Council's participation in a pan-London procurement for a web-based system to include a 'front-end' portal, joined up partner notification and home/self-sampling.
2. Approve the Council's participation in North West London (NWL) outer sub-regional arrangements, with Brent Council and Ealing Council for the procurement of Genitourinary Medicine (GUM) and Contraception and Sexual Health Service (CaSH) Services and other local Authority commissioned sexual health services (primary care sexual health services, outreach and prevention including HIV).
3. Delegate authority to award contracts, as set out in the recommendations 1 - 2 above, to the Director of Public Health (or appropriate Director), following consultation with the Corporate Director of People, Chief Financial Officer and the Portfolio Holders for Finance and Major Contracts and Public Health, Equality and Wellbeing (or appropriate alternatives).
4. Delegate authority to the Director of Public Health to approve the Council's participation in pan-London agreements on cross charging and lead commissioning and to enter into any associated legal agreements.
5. Note the progress made in developing options for the future commissioning and procurement of GUM services and the named inclusion of the Harrow and Barnet Council onto the Prior Indicative Notice (PIN) and in the Official Journal of European Union (OJEU).

Reason: (For recommendations)

GUM and CaSH are statutory services and the contracts will be funded wholly from the Public Health budget allocation.

The contracts in question have individual contract values in excess of £500,000 and therefore Cabinet approval is required to:

1. procure a new service
2. to enter any collaborative arrangements with other London boroughs

2. Section 2 – Report

2.1. Introduction

2.1.1. 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).

2.1.2. The current sexual health services commissioned by local authorities are based on historic supply-led and designed models.

2.1.3. 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 aware for example that LAs must save approximately 6.2% on the public health grant reduction within this financial year and it is likely that there will be further on-going reductions within the Comprehensive Spending Review announcement at the end of November..

- 2.1.4. Members should note that Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) are statutory services. 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.
- 2.1.5. It is important for Members to take into consideration the interdependency between the London councils participating in this collaboration and that any recommendations that are not approved may impact other members and affect the deliverables of the collaborative project.
- 2.1.6. It should be noted that if delegated authority to award contracts is not granted to any participating borough then the contract start date may be delayed due to the length of time required to mobilise and implement a new service model and the lead in time for cabinet reports to seek the necessary approvals.
- 2.1.7. Furthermore consideration should be taken that whilst the majority of LAs are operating on LA services contract with a 6 month termination notice period, some LAs are operating on NHS terms and conditions that require 12 month termination notice period. Any contract extension will trigger an additional requirement to serve contract termination notice potentially at the same time of the contract extension.
- 2.1.8. 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&BJPS) with the support of Harrow Council, as the host authority. However each borough is accountable for their own contracts.
- 2.1.9. In November 2014, Cabinet approved the following:
 - the extension of the Contraception and Sexual Health Service (CaSH) contracts until March 2017
 - for B&HJPHS to participate in collaborative procurements, where appropriate and repeat the negotiation and direct award of Genitourinary Medicine contracts for 2015/2016 and 2016/2017.
- 2.1.10. The Sexual Health Strategy 2015-2020, which has been accepted by the Health and Wellbeing Board for Harrow and Barnet in 2015, provides the strategic direction for the commissioning and delivery of future local sexual health services. See Appendix 1 and 2 for the Sexual Health Strategies for each borough.

2.1.11. Barnet and Harrow key objectives are as follows:

- To prevent and reduce the transmission of sexually transmitted infections (STIs).
- To reduce the prevalence of undiagnosed HIV infection and improve early diagnosis particularly among target groups
- To expand the provision of sexual health and reproductive services in primary care and community settings
- To increase the uptake of contraception throughout the Borough by providing more choice in different healthcare settings
- To reduce the rates of unintended pregnancies particularly repeat pregnancies.
- To improve the provision of services designed for young people's sexual health needs and to promote sex and relationship education.
- To promote the welfare of children and reduce the risks of child sexual exploitation (CSE) in Barnet
- To reduce the stigma associated with HIV and STIs.
- To expand sexual health promotion and reduce sexual health inequalities among vulnerable groups

2.2. Options considered

2.2.1. As part of the London Sexual Health Transformation Project, officers have reviewed 3 main options for commissioning the sexual health services.

Option 1: Do nothing. Current system remains unchanged. (See section 3 - Current Situation)

Option 2: Develop a networked system of services either on a 22 borough wide and sub-regional basis. This is the preferred option.

Option 3: To focus on the development of a local sexual health service model that includes Level 3 (testing and treatment of complex STIs) reducing dependence on central London services.

2.2.2. **Option 2 – Develop a networked system of services either on a 22 borough wide and sub-regional basis** (preferred option) - 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.

2.2.3. 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).

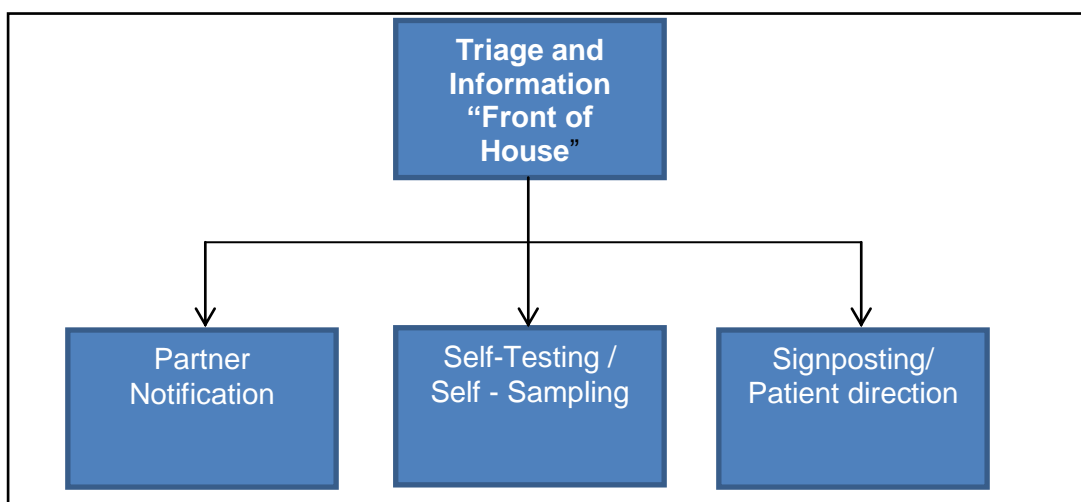


Figure 1: Scope of Pan-London Online Procurement Project

2.2.4. 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.

2.2.5. 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.

2.2.6. 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.

2.2.7. 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.

2.2.8. 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.

- 2.2.9. It is important for members to take into consideration the interdependencies between the central procurement of the Pan-London Online Portal, the sub-regional procurement and the commissioning outcomes. A delay in delivering or implementing the results of the procurement of the Pan-London On-line Portal or the providers successfully implementing the service is likely to adversely effect the results achieved by the sub-regional procurement.
- 2.2.10. **Option 3: To focus on the development of a local sexual health service model that includes Level 3, reducing dependence on central London services.** 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 option 2, 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.
- 2.2.11. 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, there were a total of 10,748 attendances at GUM clinics by Harrow residents. The majority of activity in London was accessed at Northwick Park Hospital (69%); the rest was in Westminster (10%), Barnet (6%), Camden (5%) and other London Boroughs (11%). 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%).
- 2.2.12. 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.

2.3. Background

- 2.3.1. B&HJ Public Health Service 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.
- 2.3.2. 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 13/14 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 the providers the councils achieved an avoided cost of £2.6m (9.1%) in 13/14 and avoided cost of £2.5m (6.5%) in 14/15.
- 2.3.3. The focus of the work has been on GUM services which are paid for on a 'payment per unit of activity basis': whereas Contraception and Sexual Health (CaSH) service are block contracts.
- 2.3.4. 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 26 councils as Hounslow, Richmond, Havering and Kingston have now joined the LSHTP.
- 2.3.5. Councils are responsible for providing 'open access' services for the diagnosis and treatment of Sexually Transmitted Infections (STI's) and for contraception. The STI treatment services are provided on an outpatient basis. Councils are not responsible for contraception that falls within the remit of the GMS contract or for terminations. They are responsible for the prevention and diagnosis of HIV (except where HIV testing is clinically

indicated in CCG or NHSE commissioned services), but are not responsible for the treatment and care of HIV patients.

3. Current situation

- 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 Appendix 1 and 2 for Sexual Health Strategy for local epidemiology for both Barnet and Harrow.
- 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.

Services for Harrow residents

- 3.1.5. Public Health England records (GUMCAD) show that in 2013 Harrow residents attended 10,748 appointments in GUM Services across England, with over 60% of attendances taking place locally at Northwick Park Hospital.
- 3.1.6. In the main, the CASH service is delivered by LNWHT from Caryl Thomas Clinic, with a satellite service from Alexandra Avenue Health Centre. The service also delivers an outreach service for young people called 'Clinic in a Box' and a Sex and Relationship Education (SRE) programme in schools. In 2014/15, the CASH service had almost 15,000 attendances, of which 75% were Harrow residents. 'Clinic in a Box' delivered 417 sessions in 2014/15 in 15 locations across the borough, which included schools, colleges and informal youth settings.
- 3.1.7. In addition, GPs are commissioned to deliver contraceptive implants and IUCD. In 2014/15, there were a combined number of 928 appointments relating to these **contraceptives**. Pharmacies in Harrow are also

commissioned to provide Emergency Hormonal Contraception (EHC); 145 EHC were dispensed in 2012-13.

Services for Barnet residents

- 3.1.8. 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 are 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 Clare 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.
- 3.1.9. 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.
- 3.1.10. 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.

3.2. Why a change is needed

3.2.1. London context

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.

3.2.2. From this work, the project team developed case for change which is based on 5 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.

3.2.3. The case for change leads to 2 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

3.2.4. Harrow – service review

A service review was undertaken in the London Borough of Harrow between May and October 2015. Key stakeholders and local residents were invited to participate in the service review, which comprised of focus groups, interviews and surveys. To date, a range surveys have been completed by a variety of stakeholders: service provider staff (62), GPs (12), pharmacies (8), service users (239) and young people (132). Focus groups are currently been undertaken with young people, Black and Ethnic Minority males and females and Lesbian, Gay, Bisexual and Transgender (LGBT).

The Harrow service review set out to capture information on the following themes and highlights elements of the current sexual provision that needs improvement and development. These findings along with the needs assessment will inform the new service model. The initial findings are set out below:

- **Knowledge of sexual health**
The initial findings from the stakeholder surveys are as follows: 79% agreed with the statement that 'I understand the Harrow sexual health referral pathway' and 83% agreed that "patients/users are dealt with effectively and sensitively once they are referred into the service". 73% of respondents agreed that there is "effective signposting between Harrow sexual health services"
- **Sexual health promotion and education**
Similar to Barnet, Harrow stakeholders believed that prevention was not high enough on the agenda. 53% of survey respondents stated that the information they had received was good, with 58% stating

that more information should be available in schools and colleges.

Service users were asked to identify the various ways they accessed information about sexual health services: 48% of respondents found information about local services through the internet; other popular responses included friends and family (39%).

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.

All 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**

The majority of service users accessed sexual health services for the following reasons: “wanted a checkup to make sure I didn’t have an infection” (81%); “wanted a contraception” (79%) and because they had “positive experience previously” (65%).

The key barriers identified by service users included: embarrassment (87%); unaware of services available (82%); concerned they will be judged (72%), opening times not being convenient (69%).

- **Needs and priority target groups**

Service users were asked if services should be targeted at any particular groups: 25% stated that more work should be targeted at those at risk, with 23% identifying young people as a particular target group.

Most stakeholders felt that the needs of most target groups were well served within the current provision. Less than 50% of stakeholders identified the need to target service provision at the following groups: sex workers, vulnerable adults, drug users and those from the following communities LGBT, BME and men who have sex with men.

- **Experience of services**

Over 90% of service users stated that they had a positive experience of sexual health services.

3.2.5. **Barnet – Service Review**

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).

3.2.6. 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.

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

3.2.8. The London Sexual Health Transformation project, the Local Sexual Health Strategy and the initial findings from the service review highlight the need for 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.

3.2.9 The commissioning and provision of an integrated service model is supported by professional guidance from FSRH, BASHH, BHIVA, MEDFASH, RCOG and NICE¹. It is also supported by Department of Health and Public Health England.

3.3. Procurement Approach

3.3.1. 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.

3.3.2. Following the procurement outcome and in recognition of the boroughs' interdependencies and the existence of similar interdependencies with all major GUM providers, the collaborating councils will consider the development of a single commissioning unit either hosted by a LA or commissioned from a specialist commissioning organisation. This service will provide oversight of the system to ensure it works and delivers optimally.

3.3.3. Pan-London Online Procurement Project

The scope of the Pan-London Online Procurement Project incorporates the following elements (as set out above)

- Triage and Information ("Front of house");
- Self-Testing/Self-Sampling;

¹ See Appendix A for Glossary of Terms

- Partner Notification; and
 - Signposting/ Patient Direction and where possible Appointments (Booking system) (dependent on ability to interface with existing clinic systems).
- 3.3.4. It is envisaged that each element (excluding appointments, which will form part of the provision of Triage and Information) will constitute a separate lot, to be procured concurrently. This assumption is predicated on prior engagement with online testing providers, which supports the belief in discrete areas of capability, i.e. capability in self-testing does not confer equivalent aptitude in design and build of the Triage and Information module (or ability to select the optimum sources of provision via a lead/sub-contract mechanism).
- 3.3.5. In particular, there are few examples of joined up partner notification systems and none of the current providers of home sampling services have proven competence in this area. Consequently, it is proposed that providers will be awarded lots as determined by the procurement process and evaluation model, with collective integration of service components (irrespective of individual provider award) a condition of participation. The procurement process itself is perceived to require and/or benefit from an element of dialogue/negotiation, and will follow a competitive dialogue or competitive procedure with negotiation route.
- 3.3.6. Prior engagement with providers noted that delivering clinically effective, cost effective partner notification is one of the key challenges to sexual health service providers. The use of technology has meant individuals can access their results in 'real time' and pass on information to partners via instant messaging however ascertaining and monitoring whether partners access testing and treatment is problematic.
- 3.3.7. The costs of the web based service will be met from baseline clinic budgets. There are no expected savings attributable to this service but it will support the delivery of savings as it will enable clinics to undertake partner notification (PN) activities more efficiently and effectively.
- 3.3.8. The joined up PN should allow current services to release further efficiencies. In discussions, providers have indicated that the current system for partner notification is a major draw on staff time. By having a shared database/system for partner notification the staff time taken to validate that patients have been seen and treated will be significantly reduced. The full impact of this will be dependent on the system of PN commissioned. An estimate of what may be required in terms of central management and delivery of joined up PN has been undertaken and this comes to £627k per annum for London. One provider has already proposed a cost of £40k per clinic per annum i.e. £1,300k per annum. We consider that a system within this range would offer good value representing between 0.6% and 1.2% of total contract value.
- 3.3.9. It is proposed therefore to carry out a concurrent and coterminous Pan-London Online Procurement and award contracts for a minimum term of 5 years aligning with the GUM procurement which will ensure that providers

can focus on the clinical aspects of the service requirement necessary to deliver transformed services.

3.3.10. Officers seek approval for the Council's participation in a pan London procurement for a web-based system to include a 'front-end' portal, joined up partner notification and self-testing.

3.3.11. The proposed initial contract term of the Pan-London Online Procurement is envisaged to slightly precede the Sexual Health Service procurement. The aim however is for the outcome to be available for the main stage of SH procurement (i.e. the detailed stage of the CPN estimated to take place around April – June 2016). Also the actual time that the 'front end portal' will go live is likely to vary in each borough and it should be noted that the self-testing element will only be switched on as each borough determines it is ready i.e. has procured local services. An estimate of the Pan-London Online contract(s) term will be in the region of 6 years, allowing for the 'front end' to commence first estimated October 2016 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. This is realigned with the SH procurement contract term stated in paragraph 3.4.9.

Indicative SH On-Line Procurement Timescales:

Market Engagement, Procurement Process Preparation	December 2015 – January 2016
Procurement Process Contract Award	January - September 2016
Mobilisation & Staged Contract Start	October 2016 onwards – April 2017

Sub regional procurement

3.3.12. It is recommended that GUM and CaSH are 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.

3.3.13. 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. See paragraph 2.2.11 for patient flow data for Barnet and Harrow.

3.3.14. Furthermore as stated in paragraph 2.17 consideration should be taken to the termination notice period and the effect of any contract extension.

3.3.15. This intelligence has informed the regional proposals detailed below. It is proposed that Harrow Council will lead the procurement for the North West London (outer region) and Barnet Council will be part of the North Central London sub-regional procurement, which will be led by Camden Council.

The sub regions proposed are:

North West London – NWL split into two sub regions NWL inner and NWL outer	
NWL inner Brent, Harrow , Ealing, NWL outer 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

● London GUM clinic

- 1 Archway Sexual Health Clinic (GUM)
- 2 Barking Hospital
- 3 Barnet Hospital
- 4 Beckenham Hospital
- 5 Central Middlesex Hospital
- 6 Charing Cross Hospital
- 7 Croydon University Hospital
- 8 Dean Street Clinic
- 9 Ealing Hospital, Pasteur Suite
- 10 Enfield Highway Hub
- 11 Guy's Hospital
- 12 Homerton Hospital
- 13 John Hunter Clinic
- 14 King's College Hospital NHS Foundation Tru
- 15 Kingston Hospital
- 16 Margaret Pyke Centre (GUM)
- 17 Mortimer Market Centre
- 18 Newham General Hospital
- 19 Northwick Park Hospital
- 20 Queen Mary's Hospital (GUM)
- 21 Queen's Hospital
- 22 St Ann's Hospital
- 23 St Bartholomew's Hospital
- 24 St George's Hospital (GUM)
- 25 St Helier Hospital
- 26 St Mary's Hospital London
- 27 St Thomas' Hospital
- 28 The Royal Free Hospital
- 29 The Royal London Hospital
- 30 Town Clinic
- 31 Trafalgar Clinic
- 32 Tudor Centre
- 33 Waldron Health Centre
- 34 West Middlesex University Hospital
- 35 Whipps Cross University Hospital



3.3.16. Officers seek authority to participate in a collaborative procurement for Barnet and Harrow as highlighted above for 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.

3.4. Procurement Timetable

3.4.1. It is intended that the sub-regional procurement will be undertaken using the Competitive Procedure with Negotiation (CPN) under the Public Contract Regulations 2015. Most procurements are undertaken using the open or restricted (*invitation to tender*) routes. Under these the procuring organisation sets out what services are required in the form of a detailed specification and seeks submissions from bidders; with a successful bidder appointed on the basis of price, quality and other appropriate considerations.

3.4.2. CPN allows the organisation to work with interested parties to design/establish with sufficient precision the specification. This approach is more flexible and allows for more tailored and innovative specifications and solutions to be developed. Given the wider transformational change and phasing this enables greater flexibility and potentially greater benefits, both financial and non-financial in terms of greater, integrated and improved access service improvements to residents. It should be

noted that the grounds for using CPN are harmonised with the grounds permitting use of the competitive dialogue procedure.

3.4.3. There are several advantages to this. The opening up of the development/finalising of the specification with potential bidders will allow bidders to draw on their experience and knowledge to ensure that a bespoke solution is created for London. Many bidders will have experience of delivering such services elsewhere and will be well placed to work with clinical commissioners to design a high quality service model.

3.4.4. At this stage, it is not possible to articulate the detailed configuration of the new services, as the CPN process itself will help in the design of this. However, the following considerations are pertinent:

- Patients with complex needs/high risk groups may need to receive their treatment within a clinic setting. In developing the final specifications, clinical specialists will be engaged to ensure the proposed model is clinically safe and appropriate.
- The dialogue phase will assist in clarifying the percentage of current activity that will be diverted out of a clinical setting and in particular diagnostics out of acute settings.
- The service may be provided by someone other than the current provider. As a result of market sounding that has been undertaken the project team has determined that nearly all the existing NHS Trusts have expressed an interest. In addition a number of private and not for profit organisations have expressed an interest in providing some or all of the required services.
- Most of the services will be provided within a clinic setting possibly complemented by community settings. We will work with the bidders to identify economies of scale for delivery. That is, some elements of the services may need to be delivered in one location, whereas others could be delivered at several locations within each sub region or even by alternative service means like on-line testing and/or primary care providers such as, pharmacies and GPs (especially when the service is high volume and less complex/risk – asymptomatic–).

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

- i. Good quality services are accessible to all London residents and visitors;
- ii. Level 3² 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.
- iii. London councils are commissioning effectively including seeking cost effective benefits from lower transaction and operating costs

² See Appendix A for definition of Levels

- 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

The Sexual Health indicative procurement project timetable is as follows:

Competitive Procedure with Negotiation using PIN as a call for competition	PLANNED START DATE	PLANNED FINISH DATE
Issue Prior Indicative Notice(PIN) as a call for competition	22-Jan-16	22-Feb-16
Send Invitation to confirm interest to economic operators	23-Feb-16	04-Apr-16
allow 30 days	24-Feb-16	04-Apr-16
closing date of receipt of confirmation of interest	04-Apr-16	04-Apr-16
Despatch of invitation to submit initial tender	05-Apr-16	05-May-16
Time for return by mutual agreement or min 10 days if not agreed	05-Apr-16	05-May-16
Initial tender deadline	05-May-16	05-May-16
Evaluate initial tender submissions	06-May-16	31-May-16
Despatch of invitation to negotiate tender	01-Jun-16	03-Jun-16
negotiation phase 3 weeks	06-Jun-16	24-Jun-16
Issue Call for Final Tenders (CFT)	27-Jun-16	27-Jun-16
No minimum period common deadline to be set for all tenderers	28-Jun-16	18-Jul-16
FT deadline	18-Jul-16	18-Jul-16
FT Tender evaluation	19-Jul-16	02-Sep-16
FT Tender moderation evaluation if required	05-Sep-16	09-Sep-16
Draft Award recommendation report	12-Sep-16	16-Sep-16
DPH Briefing & Officer Clearance	19-Sep-16	23-Sep-16
Portfolio Holder and stakeholder consultation	26-Sep-16	30-Sep-16
Draft Award Notification Letters	26-Sep-16	30-Sep-16
Notification & Voluntary** Standstill Period	03-Oct-16	14-Oct-16
Successful Supplier Notified	17-Oct-16	21-Oct-16
Contract Award	24-Oct-16	28-Oct-16
Contract Transition Period (allowing for possible TUPE)	31-Oct-16	31-Mar-17
Contract Handover	01-Mar-17	31-Mar-17
Contract Start	01-Apr-17	01-Apr-17

3.4.6. Current Contract Values

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 and for Harrow it was £2.6m.

3.4.7. 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.

- 3.4.8. The existing contracts for GUM and CaSH Services were previously extended and they will expire on 31st March 2017. Procurement will include both services.
- 3.4.9. 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.
- 3.4.10. 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.
- 3.4.11. 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)
- 3.4.12. For Harrow and Barnet based on current spend the estimated aggregate value of the proposed GUM contract for 5 years is in the region of (£27.4 million) plus 4 years (£22.2 million.) = £49.6 million. Harrow: (£15.6 million) Barnet: (£33.9 million). All the above figures are subject to funding.
- 3.4.13. The current CaSH contract value is **£616,000 (Harrow); £929,749 (Barnet)**.
- 3.4.14. The Primary Care current spend is **£48,000 (Harrow); £65,000 (Barnet)**.
- 3.4.15. The HIV testing (Home Sampling) spend is **£24,200 (Harrow); £38,000 (Barnet)**.
- 3.4.16. 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.

3.4.17. 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 budget pressures the council need to get the best possible price. To achieve this, the recommendation is:

- 50% quality and 50% price/commercial considerations.

3.4.18.

- Harrow, as part of the North West Outer Sub-region procurement at 50% quality and 50% price
- Barnet, as part of the North Central Sub-region procurement at 50% quality and 50% price.

The project team is in the process of developing the sub criteria and evaluation methodology.

3.5. Environmental Implications

3.5.1. The collaborative procurement will seek to minimise its environmental impact by implementing energy and carbon reduction via its procurement process. Through the evaluation exercise as part of the procurement and contract monitoring, providers will be required to pay due regard for the environmental impact during service delivery. They will need to implement measures to mitigate the environmental impact.

3.6. Risk Management Implications

3.6.1. 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.

3.6.2. 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.

3.6.3. 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.

- 3.6.4. 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.
- 3.6.5. 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 £1 billion 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.
- 3.6.6. 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).
- 3.6.7. In any collaborative procurement, it is essential that clear and effective interborough 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.

3.7. Legal Implications

- 3.7.1. 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.

- 3.7.2. 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.
- 3.7.3. 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.
- 3.7.4. 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.

3.8. Financial Implications

- 3.8.1. In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget.
- 3.8.2. The Public Health Grant is currently ring fenced but given the financial climate it is possible that this will be transferred into councils revenue support grant within the contract term. In addition the allocation is likely to be reduced in line with wider reductions in local government funding. In 2015-2016 an in year cut of £200m nationally has been proposed.
- 3.8.3. 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
- 3.8.4. The starting point for the grant for 2016/17 for Barnet totals £17.519m and for Harrow £12.3m and includes the annual allocation for health visiting, but does not reflect any potential changes which are likely to arise from the spending review to be announced on 25th November and the current consultation on the ACRA formula. Annual grant reductions, potentially in the region of 5% per annum over the next four years, are possible.
- 3.8.5. The proportion of the Health Visiting PH grant or the value for each Borough is (Barnet £5.184m Harrow £3.154m)
- 3.8.6. Sexual Health spend proportion of the non-HV element of the grant 36% Barnet, 29% Harrow
- 3.8.7. 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.

3.8.8. 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.

3.9. Efficiencies

3.9.1. This procurement, which is part of a wider sexual health transformation project, is expected to deliver savings. The following areas are ways in which 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

3.9.2. The anticipated 2016-17 budget for GUM services for Barnet total £4.415m and for Harrow £2.641m.

3.9.3. The commissioning intentions detailed elsewhere on this agenda propose savings of £105k (approx. 4% of the estimated 16/17 budget across sexual health services) for Harrow for 2017/18 in relation to the amalgamation of discrete areas of work within a new integrated Contraceptive and Sexual Health Service from April 2017. Similarly 10% for Barnet.

3.9.4. 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.

3.9.5. 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.

3.9.6. Further updates around the procurement process, including the potential level of savings that are likely to be delivered will be provided to Cabinet following the procurement, via a report containing a project update.

3.10. Equalities implications / Public Sector Equality Duty

3.10.1. The Council will need to comply with the Equality Act 2010 in the provision of Public Health Services and the NHS Constitution when making decisions affecting the delivery of public health in its area. 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.

3.11. Council Priorities

3.11.1. The services set out in this report contribute to the delivery of the following Council's priorities by ensuring the health and wellbeing of local residents. These services ensure that vulnerable residents have access to the information, support, diagnosis and treatment they require to achieve optimum health. The service user's engagement in these services also has a positive impact on the family and the wider community.

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

3.11.2. For example for every £1 spent on contraception, we save £12.50. Investment in sexual health education, awareness and treatment saves money - all of which are associated with significant burden to public services and ultimately the tax payer. Investment in sexual health and contraceptive services could save more than £5 billion which equates to 23,800 sexual health nurses over 7 years. Sexual Health Services provide a positive return on investment both financially and socially.

4. Section - Statutory Officer Clearance

Name: Dawn Calvert	<input checked="" type="checkbox"/>	on behalf of the Chief Financial Officer
Date: 30 November 2015		
Name: Sarah Inverary	<input checked="" type="checkbox"/>	on behalf of the Monitoring Officer
Date: 30 November 2015		

Ward Councillors notified:	NO, as it impacts on all Wards
EqIA carried out:	YES
EqIA cleared by:	Carole Yarde

5. Section - Contact Details and Background Papers

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Background Papers:

1. Cabinet Paper 20th November 2014 – item 65.

<http://www.harrow.gov.uk/www2/documents/s117466/Public%20Health%20Contracts%20-%20Main%20Report.pdf>

2. Unprotected Nation report - PAINTING A PICTURE OF SEXUALHEALTH IN BRITAIN 2013-2020.

<http://www.fpa.org.uk/sites/default/files/unprotected-nation-2013-illustrated.pdf>

**Call-In Waived by the
Chairman of Overview
and Scrutiny
Committee**

NOT APPLICABLE

[Call-in applies]