REPORT FOR: HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	3 February 2016
Subject:	London Sexual Health Transformation Project
Responsible Officer:	Andrew Howe – Director of Public Health
Scrutiny Lead Member area:	Councillor Chris Mote, Policy Lead Member & Councillor Margaret Davine, Performance Lead Member
Exempt:	No
Wards affected:	All wards
Enclosures:	Appendix 1 – Definitions, Commissioning responsibility, Glossary of Terms Appendix 2 – Harrow – Sexual Health Strategy 2015 – 2020 Appendix 3 – Equality Impact Assessment

Harrow COUNCIL LONDON

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 and Contraception and Sexual Health Service (CaSH) Services.

Recommendations:

Overview and Scrutiny to note Barnet and Harrow Joint Public Health Service's plans to:

a. Participate in a pan-London procurement for a web-based system which includes a 'front-end' portal, joined up partner notification and home/self-sampling

b. Lead the North West London (Outer) sub-region group for the procurement of GUM and Contraceptive and Sexual Health Services (CASH), including primary care, outreach and preventive services.

2. Report

2.1. Introduction

2.1.1. This report sets out how the Council will fulfil its obligation to commission Genitourinary Medicine Services (GUM) and Contraception and Sexual Health (CaSH) services 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.

2.1.2. 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).

2.1.3. Local authorities are responsible for commissioning 'open access' services (including free STI testing and treatment, notification of sexual partners of infected persons and freed provision of contraception). They are also responsible for the provision of specialist services, which includes young people's sexual health, teenage pregnancy services, outreach, and HIV prevention, and sexual health promotion, services in schools, colleges and pharmacies.

2.1.4. 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.

2.1.5. As these contracts are due to expire in March 2017, the Public Health Service acquired permission from Harrow Council on 10 December 2015 to procure new sexual health services and to enter any collaborative arrangements with other London boroughs.

2.1.6. 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 the Council to achieve the objectives set out in the Sexual Health Strategy and improve sexual health outcomes

2.1.7. **The 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 Harrow
- To reduce the stigma associated with HIV and STIs.
- To expand sexual health promotion and reduce sexual health inequalities among vulnerable group.

2.1.8. 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.

2.1.9. **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.

2.1.10. 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).

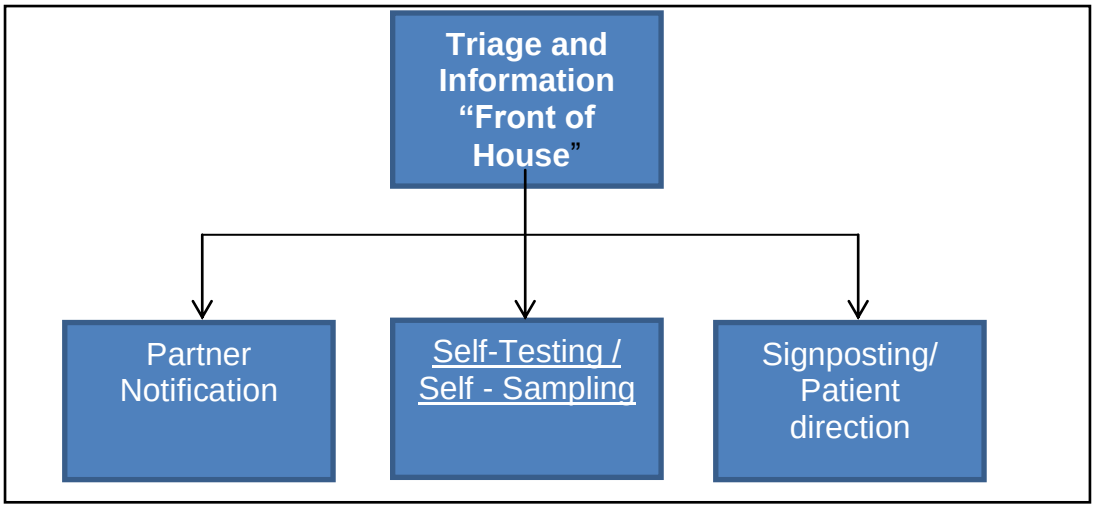


Figure 1: Scope of Pan-London Online Procurement Project

2.1.11. 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.

2.1.12. 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.

2.1.13. 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.

2.1.14. 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.

2.1.15. The next phase for the project is for the collaborating boroughs to proceed to the re-procurement of these services, with new contracts in place by April 2017.

2.1.16. **Sub regional procurement**

2.1.17. GUM and CaSH 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. Therefore, London has been divided into sub regions for the procurement of GUM and CaSH services.

2.1.18. 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 adjacent boroughs.

2.1.19. As an open access service, there is an established arrangement across the Country for cross-charging, with most of the activity for 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%).

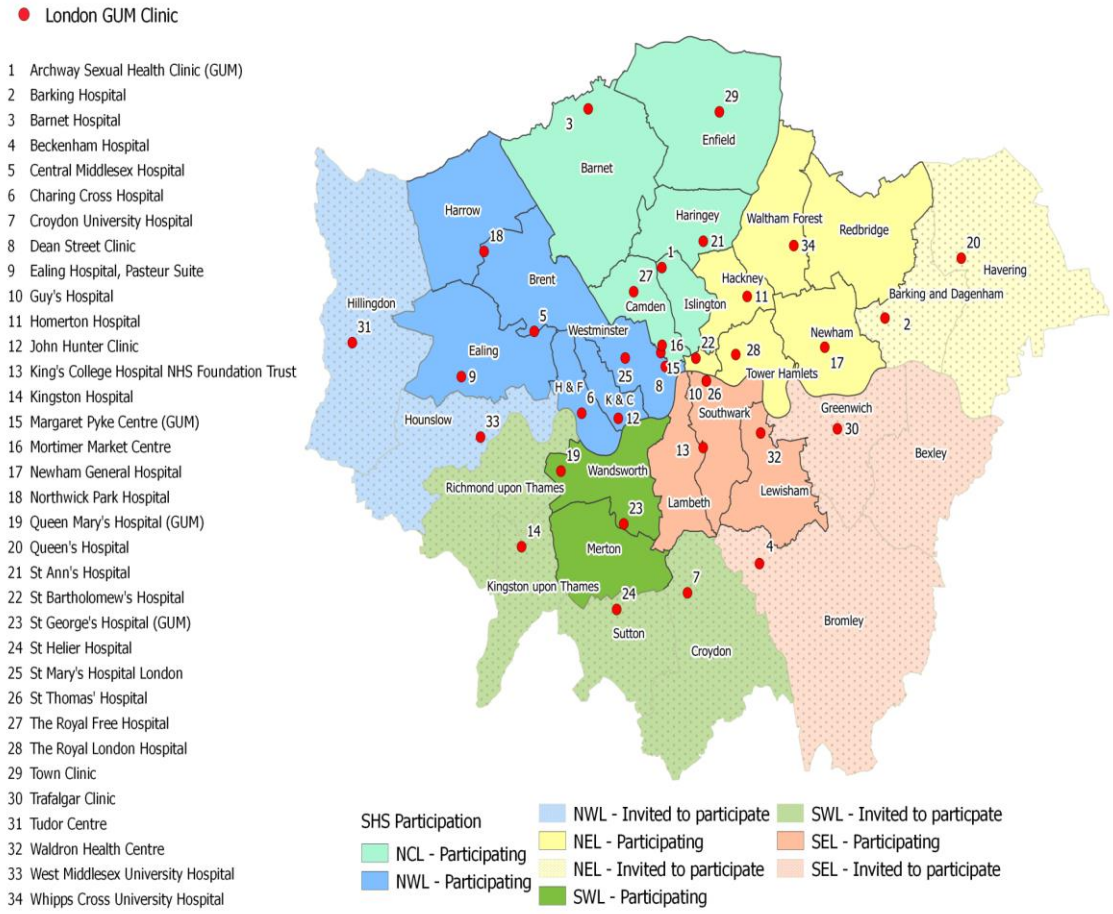
2.1.20. This intelligence has informed the regional proposals detailed below. It is proposed that the London boroughs of Harrow, Ealing and Brent will jointly procure new services for the North West London (outer region); Harrow Council will be the project lead.

The sub regions proposed are:

North West London – NWL split into two sub regions NWL inner and NWL outer	
NWL outer 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.	Camden and Islington
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 participating on the online procurement only. Croydon, 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



2.2. Current situation

2.2.1. Local Authorities (LAs) are facing unprecedented challenges in improving the quality of sexual health services, whilst dealing with increased demand and a backdrop of reduced funding. 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.

2.2.2. 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.

2.2.3. 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.

2.2.4. 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.

2.2.5. H&B Joint 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.

2.2.6. 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).

2.2.7. 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 were 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.

2.2.8. The London Sexual Health Transformation Programme developed a case for change which recognised the following issues:

- 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 for Sexual Health Strategy for local epidemiology for Harrow
- 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.

2.2.9. To assess the current state of GUM services in London, the project team also undertook 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.

2.2.10. 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

Local Sexual Health Provision

2.2.11. 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.

2.2.12. In the main, the CASH service is delivered by The London North West Healthcare Trust (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.

Harrow – service review

2.2.13. 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. A range of surveys were completed by a variety of stakeholders: service provider staff (62), GPs (12), pharmacies (8), service users (239) and young people (132). Focus groups were undertaken with young people, Black and Ethnic Minority males and females and Lesbian, Gay, Bisexual and Transgender (LGBT).

2.2.14. 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.

2.2.15. **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**
  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.

2.2.16. The local service review and need assessment highlights the importance of health education and raising awareness of 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.

2.2.17. The London Sexual Health Transformation project, the Local Sexual Health Strategy and the initial findings from the service review highlights the need for change in the way that local services are delivered in 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.

Current Contract Values

2.2.18. 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. Harrow's expenditure for all sexual health services for 2014/15 was £2.6m.

2.2.19. The current annual contract value for the CaSH service is **£616,000** and the combined value of all Primary Care is **£48,000**

2.2.20. The annual HIV testing (Home Sampling) spend is **£24,200 (Harrow);**

2.2.21. The current system of contracting services involves re-negotiating tariffs are 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. 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.

2.2.22. 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. Implications of the Recommendation

3.1. Legal comments

3.1.1. 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.

3.1.2. 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.

3.1.3. 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.

3.1.4. 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.

3.2. Financial Implications

3.2.1. In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget.

3.2.2. 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.

3.2.3. 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.

3.2.4. The starting point for the grant for 2016/17 for Harrow totals £12.3m, 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. Following the spending review, Public Health England confirmed average annual grant reductions of 3.9% until 20/21 with the ring fence confirmed to March 2018, and consultation to move to a model funded by business rates after this date. Grant allocations for 2016/17 are yet to be announced.

3.2.5. Sexual Health spend proportion of the non-HV element of the grant is 28% Harrow. 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.

3.2.6. Whilst the ring-fence is maintained, any efficiency achieved on public health expenditure (including that delivered through procurement programmes) delivers 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.

3.2.7. 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. Harrow expenditure for all sexual health services for 2014/15 was £2.6m

3.3. Performance Issues

3.3.1. Public Health reports to the Harrow Improvement Board on the following indicators:

% of people with needs relating to STIs who have a record of being offered an HIV test at first attendance (excluding those already diagnosed HIV positive)

% of people with needs relating to STIs who have a record of

accepting an HIV test at first attendance (excluding those already diagnosed HIV positive)

3.3.2. The current provider is exceeding these annual indicators. The new service will be expected to maintain these targets and enable the Council to achieve the objectives set out in the Sexual Health Strategy 2015 - 2020. A wider range of indicators will be introduced to improve the sexual and reproductive health of local residents, particularly high risk and vulnerable groups. These indicators will be associated with reducing unplanned pregnancies and sexually transmitted diseases.

3.4. Environmental Impact

3.4.1. 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.

3.5. Procurement.

3.5.1. 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

3.5.2. The anticipated 2016-17 budget for GUM services for Harrow is £2.641m.

3.5.3. 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.

3.5.4. 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.

3.5.5. 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.

3.5.6. 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.

3.6. 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 collaboration across 26 councils (potentially 28) London boroughs, it is estimated that 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.

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, and 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 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.

3.7. Equalities implications

3.7.1. 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.

3.8. Council Priorities

3.8.1. 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

3.8.2. 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.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards Date: 19 January 2016	x	on behalf of the* Chief Financial Officer
Name: Sarah Inverary Date: 22 January 2016	x	on behalf of the* Monitoring Officer

Ward Councillors notified:	**N/A** .

Section 4 - Contact Details and Background Papers

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Background Papers:

Appendix A - Definitions, Commissioning responsibility, Glossary of Terms
Appendix 1 – Harrow – Sexual Health Strategy 2015 – 2020
Appendix 3- Equality Impact Assessment