REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	11 May 2016
Subject:	London Sexual Health Transformation Project
Responsible Officer:	Andrew Howe, Director of Public Health, Barnet and Harrow Joint Public Health Services
Public:	Yes
Wards affected:	All
Enclosures:	Appendix 1 - Definitions, Commissioning responsibility, Glossary of Terms Appendix 2 – Harrow – Sexual Health Strategy 2015 – 2020

1 Section 1 – Summary and Recommendations

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

Recommendations:
The Board is requested to note Barnet and Harrow Joint Public Health Service's plans to participate in:

a. A pan-London procurement for a web-based system to include a 'front-end' portal and home/self-sampling

b. The Outer North West London sub-regional arrangements, with the London Boroughs of Brent and Ealing for the procurement of Genitourinary Medicine (GUM) and Contraception and Sexual Health Service (CaSH) Services (including primary care sexual health services, outreach and prevention).

2 Section 2 – Report

2.1 Current Situation

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 services (CaSH) and details the steps that will be undertaken to re-model services in collaboration with other London boroughs. It will also provide an update on progress undertaken to date to ensure that a new service model will be in place by April 2017.

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 Commisioning 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, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies.

2.1.4 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.

2.1.5 In the main, the CASH service is delivered by London North West Hospital Trust 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.

2.1.6 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.

2.1.7 It should be noted that as part of the Inter Authority Agreement between Barnet and Harrow Council, the monitoring and procurement of Public Health contracts for both boroughs are undertaken by the Harrow & Barnet Joint Public Health Service (H&BJPHS) with the support of Harrow Council, as the host authority.

2.1.8 Therefore, in line with Harrow Council's Corporate Procurement Rules (CPRs), H&BJPHS sought approval from Cabinet (November 2014) to:

- extend the Contraception and Sexual Health Service (CaSH) contracts until March 2017
- participate in collaborative procurements, where appropriate and repeat the negotiation and direct award of Genitourinary Medicine contracts for 2015/2016 and 2016/2017.

2.1.9 As these contracts are due to expire in March 2017, Harrow &Barnet JPHS acquired permission from Harrow Council on 10 December 2015, as the host authority, to procure new services and to enter any collaborative arrangements with other London boroughs, for both boroughs.

3 Why a change is needed

3.1.1 Local Authorities (LAs) are facing unprecedented challenges in providing improved quality of service provision whilst at the same time dealing with increased demand and a backdrop of reduced funding. Members will be aware that an in-year grant reduction of approximately 6.2% (£0.664mm) on the public health grant reduction was confirmed at the end of November 2015 and the Comprehensive Spending Review announced an average real time savings of 3.9% to 2020/21.

3.1.2 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 of the service puts the Council under financial uncertainty as the level of activity is unpredictable.

3.1.3 H&BJPHS are currently leading the pan London Sexual Transformation project, which aims to deliver a new collaborative commissioning model for GUM services across the capital. The key outcomes are to improve patient experience, improve sexual health outcomes and provide successful cost effective delivery of excellent services across the capital. The aim is to commission the services so that the system is operating under new contracts by April 2017.The pan London Sexual Health Transformation project was initiated in June 2014. The project evolved from work that had been undertaken by the West London Alliance (WLA) and Tri-borough councils in 2013/14 to agree prices and terms and conditions for GUM services with the major NHS providers in North West London. In 14/15 the work expanded to include Camden, Islington and Haringey. The 12 councils working together were successful in negotiating acceptable tariff prices for GUM and in implementing standard service specifications and common Key Performance Indicators (KPIs). By taking this joint approach to discussions with GUM providers, participating councils achieved an

avoided cost of £2.6m (9.1%) in 13/14 and avoided cost of £2.5m (6.5%) in 14/15.

3.1.4 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 29 councils participating in this project.

3.1.5 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.

3.1.6 From this work, the project team developed a case for change which is based on five elements:

- London has the highest rates of Sexually Transmitted Infections (STI's) in England. Rates vary significantly throughout London but even the London boroughs with the lowest rates of STIs are close to or exceed the England average. Men who have sex with men (MSM) and Black Caribbean communities have significantly higher rates of STI's than other groups
- Access to services is highly variable across London and significant numbers of residents from every London borough are accessing services in central London
- There is a significant imbalance in the commissioner/provider relationship. Service development has typically been provider-led. With several services in the London area, no single council has sufficient leverage to deliver significant system-level change
- The systems for clinical governance need improvement. Patient flows and the lack of a 'helicopter view' of what is taking place within individual services make it difficult for councils to have sufficient assurance over quality and safety
- Growth in demand for these services and costs of healthcare cannot be contained within the reducing 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.

4 Main option

4.1.1 **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 e-Service. The front door into services will be through a web-based single platform; providing residents with information about sexual health, on-line triage, signposting to the most appropriate local services 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.

The **Pan-London Online Portal** will incorporate the following elements

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

4.1.2 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.

4.1.3 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.

4.1.4 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.

4.1.5 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.

4.1.6 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 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.

4.1.7 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.

4.2 **Sub regional procurement**

4.2.1 GUM and CaSH services are to be procured on a geographical 'lots' basis across London. There are 2 primary reasons for this – firstly, it was identified through the market engagement exercise that no one bidder has the capability or capacity to be able to provide all sexual health services across London. It is proposed therefore to divide the London region into sub regions for the procurement of GUM and CaSH services.

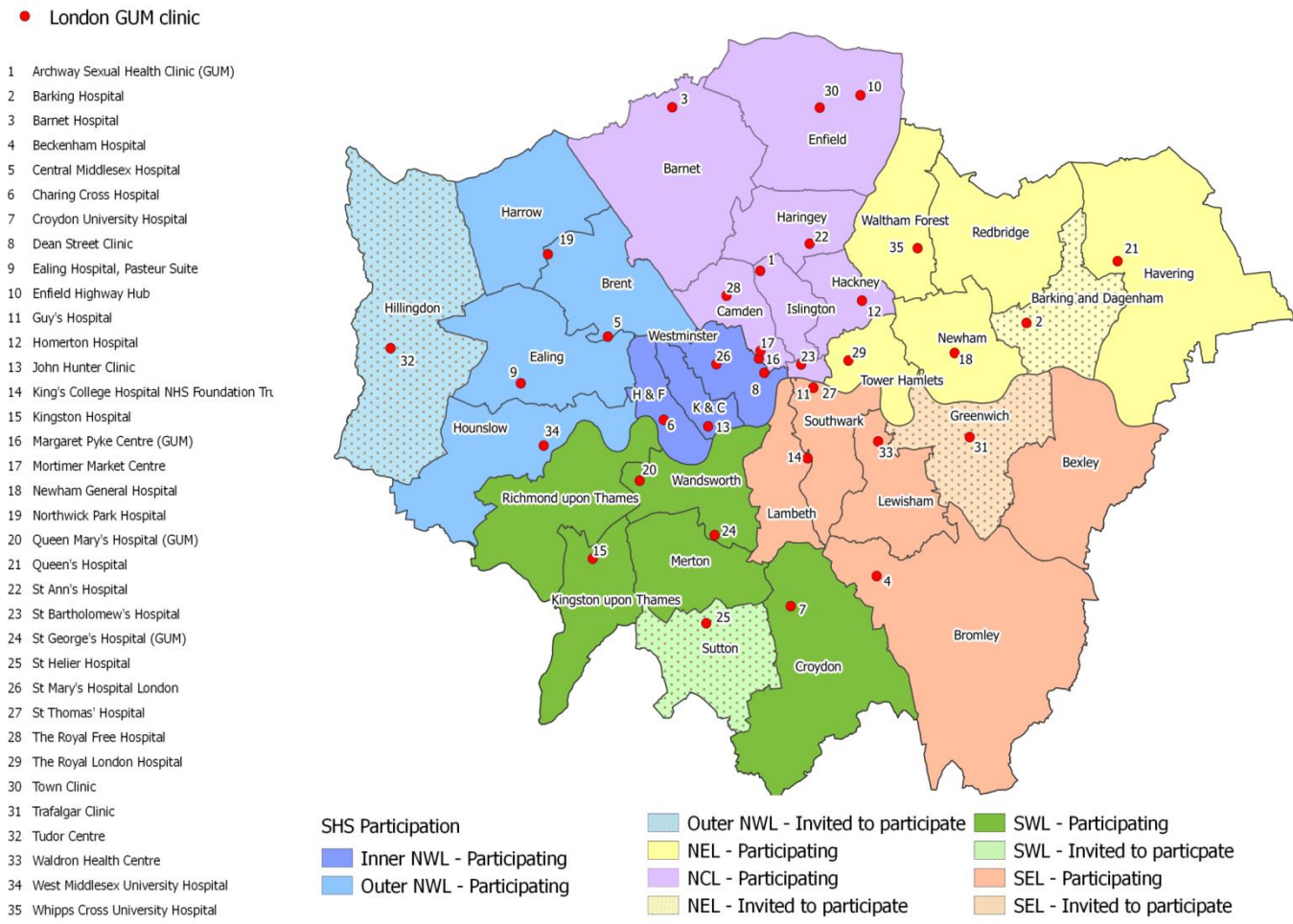
4.2.2 Secondly considerable work has been done to map and understand how patients currently move around the system. While all boroughs will have residents who attend at almost every London service the majority of people attend services either in their borough of residence or in boroughs immediately adjacent.

4.2.3 This intelligence has informed the regional proposals detailed below. LB Harrow will be part of the Outer North West London sub-regional procurement, which includes: Brent and Ealing. The sub regions are as follows:

North West London – NWL split into two sub regions NWL inner and NWL outer

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

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



4.2.4 The pan London Sexual Health Transformation project was initiated in June 2014. The project evolved from work that had been undertaken by the West London Alliance (WLA) and Tri-borough councils in 2013/14 to agree prices and terms and conditions for GUM services with the major NHS providers in North West London. In 14/15 the work expanded to include Camden, Islington and Haringey. The 12 councils working together were successful in negotiating acceptable tariff prices for GUM and in implementing standard service specifications and common Key Performance Indicators (KPIs).

4.2.5 The 12 councils agreed to jointly review the need for and provision of GUM services and recognising the interdependencies across borough boundaries, invited all other councils in London to be involved. The final group of councils who engaged in this review and contributed to project costs 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.

4.2.6 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.

4.2.7 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

4.2.8 Local Sexual Health Provision

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.

4.2.9 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.

4.2.10 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. 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).

4.2.11 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.

4.2.12 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.

4.2.13 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.

4.2.14 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.

4.2.15 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. Harrow's draft expenditure for all sexual health services for 2015/16 was £2.529m.

The current annual contract value for the CaSH service is **£616,000** and the combined value of all Primary Care is **£48,000.** The annual GUM spend in 2015/16 was £1.8m.

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

4.2.16 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.

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

5 Implications of the Recommendation

5.1 **Legal comments**

5.1.1 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.

5.1.2 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.

5.1.3 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.

5.1.4 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.

5.2 **Financial Implications**

5.2.1 In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget. Sexual Health spend represents 28% of the non-Health Visiting element of the grant in Harrow. The grant is 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 amount.

5.2.2 The comprehensive spending review released on 25 November 2015, announced that the public health grant for local authority, public health duties would remain ring fenced for 2016/17 and 2017/18. However, the government will consult on options to fully fund local authorities' public health spending from their retained business rates receipts as part of the move towards 100% business rates retention. The

indicative public health grant for 2017/18 shows a further reduction of £280k (2.5%), and this is expected to continue annually at a similar level until April 2020.

5.2.3 The commissioning intentions for 2016/17 assume a reduced level of spend of £2.6m across sexual health services. Further savings of £105k have been approved for 2017/18 as part of the MTFS, in relation to the amalgamation of discrete areas of work within a new integrated Contraceptive and Sexual Health Service from April 2017.

5.2.4 Whilst the ring-fence is maintained, and 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 services 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.

5.2.5 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 and population changes are driving demand also.

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

5.2.7 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 guarantee in the longer term.

5.3 **Performance Issues**

5.3.1 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)

5.3.2 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.

5.4 **Environmental Impact**

5.4.1 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.

5.5 **Procurement**

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

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

5.7 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.

5.8 **Risk Management Implications**

5.8.1 The key risk to achievement of outcomes within timescales is the complexity of partnership working. Some changes or waivers to individual council's policies or procedures may be required due to the nature of arrangements where significant numbers of different organisations are involved. For some inner London services, up to 8 councils will need to be involved to effectively commission the services.

5.8.2 It is important to note that service transformation and behaviour change may require clinic redirection and alternative suitable clinical premises located at "hotspots" which may not be feasible within the procurement timescales. In addition the premises need to meet all legal and planning regulations in order to deliver core services. An example where delay may occur and affect the procurement timetable may be the need of a D1 planning status for the treatment services. Whilst the

provider(s) develop their own property strategy to locate within the regions we will work with the outgoing and incoming providers to ensure that services aren't disrupted.

5.8.3 Due to the nature of the service, possible re-location of the new service may meet local opposition. LAs will need to work with residents, stakeholders, the local press and politicians to ensure the establishment of the new service is managed effectively. There is a project communication strategy addressing key messages and key audiences ensuring consistency of communication.

5.8.4 It is important that councils work closely together, any LA doing different things in their area or not delivering their part within the collaborative project will negatively impact on each other and the collaboration project.

5.8.5 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.

5.8.6 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).

5.8.7 In any collaborative procurement, it is essential that clear and effective inter-borough arrangements are put in place, not only in connection with the procurement process but also in relation to the subsequent operation of the contract. An interim collaborative governance structure with representatives from all participant LAs has been agreed pending Cabinet approval. Officers will need to establish more detailed governance arrangements. Officers will need to ensure appropriate legal, financial and other relevant advice is obtained in establishing suitable governance and professional project resources meeting procurement start of February 2016. Governance arrangements will ensure there is clear accountability and liability between the councils and appropriate binding inter authority agreements. Professional

services arrangements will ensure that there is consistency of approach, legal, procurement, financial and communications advice and appropriate programme and project management. This will be particularly important for carrying out a compliant CPN procedure whilst ensuring that any risk of challenge is eliminated.

5.9 **Equalities implications**

5.9.1 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.

5.10 **Council Priorities**

5.10.1 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

5.10.2 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

[Note: It is the author's responsibility to decide whether legal and/or financial clearances are necessary. If not, the report can be submitted without these consents].

Name: Donna Edwards	[x]	on behalf of the Chief Financial Officer

Date: 3 May 2016		
Name: Sarah Inverary Date: 13 March 2016	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**N/A**

• Section 4 - Contact Details and Background Papers

Contact:
Audrey Salmon, Head of Public Health Commissioning, Barnet and Harrow Joint Public Health Service Audrey.salmon@harrow.gov.uk

Background Papers:

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