



Cabinet
14 December 2015

**Report from the
Director of Public Health**

Wards affected:
ALL

London Sexual Health Transformation Project

1.0 Summary

- 1.1 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.

2.0 Recommendations

- 2.1 Approves 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.
- 2.2 Approves the Council's participation in the North West London: outer region, sub-regional procurement, which consists of a collaboration with Harrow and Ealing Councils (with Harrow Council acting as the Lead Authority) for the procurement of an integrated sexual health service of Genitourinary Medicine (GUM), Contraception and Sexual Health Service (CaSH) Services, Chlamydia Screening and where appropriate the inclusion of primary care sexual health services.
- 2.3 Approves an exemption from the usual tendering requirements of Contract Standing Orders 84 (a) to permit the use of Harrow Council's Contract

Standing Orders, as the Lead Authority, on the North West London outer-region sub regional collaborative procurement of the services referred to in recommendation 2.2 above and as more particularly detailed in paragraphs 3.4.12 - 3.4.16.

- 2.4 Delegate authority to award contracts, proposed under recommendations 2.1 and 2.2 above, to the Director of Public Health following consultation with the Chief Financial Officer and the Chief Legal Officer.
- 2.5 Delegate authority to the Director of Public Health in consultation with the Chief Financial Officer and Chief Legal Officer to approve the Council's participation in pan-London agreements on cross charging and lead commissioning.
- 2.7 Notes the progress made in developing options for the future commissioning and procurement of GUM services and the named inclusion of Brent Council onto the Prior Indicative Notice (PIN) and in the Official Journal of European Union (OJEU).

3.0 Detail

- 3.1 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).
- 3.2 The current sexual health services commissioned by local authorities are based on historic supply-led models.
- 3.3 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 that LAs must save 6.2% on the public health grant 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.
- 3.4 Members should note that Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) are statutory services. GUM services are open access which means that residents are entitled to visit sexual health facilities in any part of the country, without the need for a referral from a GP or other health professional, as often as they wish and without needing to be symptomatic at an average tariff cost of £159.60 for First Attendance ("FA") and £98.40 ("FU") for Follow Up. This open access requirement puts the Council under financial uncertainty as the level of activity is unpredictable.
- 3.5 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 Councils and affect the deliverables of the wider collaborative project.

- 3.6 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.
- 3.7 Members should also note the interdependency between the commissioning decisions of Central London boroughs (where many Brent residents attend services) and the delivery models of Central London GUM providers and the sub-regional procurement. The ability to deliver the desired outcomes for Brent from the sub-regional procurement is dependent on the procurement strategy in Central London as well as the appropriate changes in Central London provider behaviour and capacity.
- 3.8 Furthermore consideration should be taken that whilst the majority of Local Authorities (“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.
- 3.9 In January 2014, Cabinet approved the following recommendation:
- *Delegates authority to the Director of Public Health, in consultation with the Director of Legal & Procurement and Chief Finance Officer, to participate in the WLA negotiation of 2014/15 Genito-Urinary Medicine (“GUM”) contracts and to award direct contract(s) to existing GUM health providers, on behalf of Brent Council, and to develop arrangements to support the collaborative management of these contracts*
- 3.9.1 GUM services are open access with activity based contracts. This means Brent residents may access services anywhere without referral and the Council is liable for the cost of this activity. Many Brent residents do access services at our local provider (London North West Healthcare Trust), but others use clinics elsewhere, notably in Central London. Through collaborative negotiation, Councils including Brent have been able to negotiate acceptable tariff prices, standard service specifications and Key Performance Indicators (KPIs). For Brent this equated to £253,000 (6% of contract value) of avoided cost in 2014/15.
- 3.9.2 Recognizing the advantage of this collaboration, Cabinet approved the following:
- *In September 2014 Delegated authority to the Director of Public Health, in consultation with the Director of Legal & Procurement and Chief Finance Officer, to participate in negotiation of 2015/16 Genito-Urinary Medicine contracts and;*

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- In December 2014 *Delegated authority to the Director of Public Health, in consultation with the Director of Legal & Procurement and the Chief Finance Officer, to participate in the negotiation and direct award of 2016/17 GUM contracts.*

- 3.10 The London Sexual Health Services Transformation Project has undertaken a needs assessment, analysis of the 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. From this work, it is clear that there is a strong case for change

Options Considered

- 3.11 Officers have reviewed 3 main options for commissioning the sexual health services.

Option 1: Do nothing. Current system remains unchanged. (See section 3.32 - Current Situation)

Option 2: Develop a networked system of services either on a 22 (now 28) borough wide and/or sub-regional basis. **This is the preferred option.**

Option 3: LAs to focus on development of a local service model that includes Level 3¹ services reducing dependence on Central London services.

- 3.12 **Option 2 – Develop a networked system of services either on a 22 (now 28) 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 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.

- 3.13 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).

¹ See Appendix A for definition of Levels

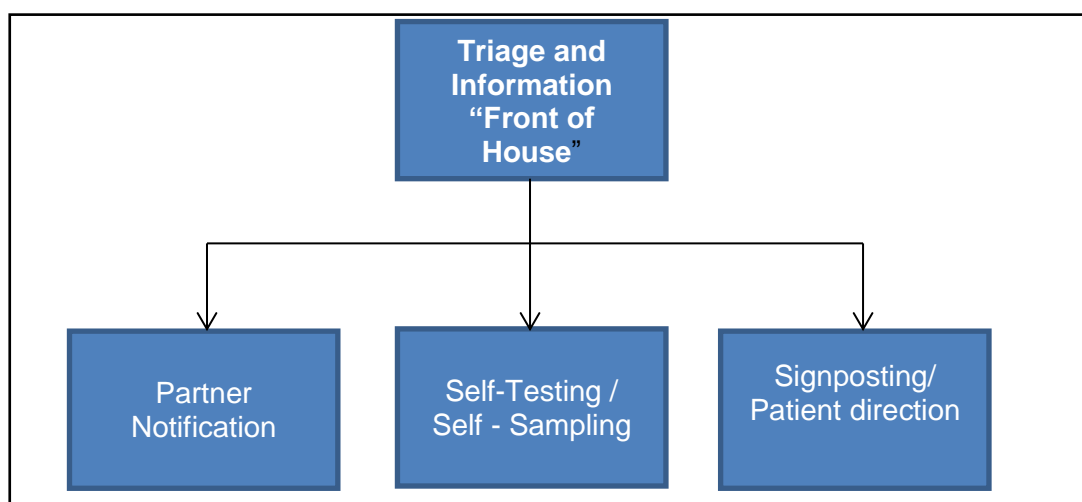


Figure 1: Scope of Pan-London Online Procurement Project

- 3.14 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.
- 3.15 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.
- 3.16 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.
- 3.17 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 at clinics currently do not have symptoms.
- 3.18 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. 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 change 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.

- 3.19 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 online portal, or in the providers successfully implementing the service, is likely to adversely effect the results achieved by the sub-regional procurement.
- 3.20 **Option 3: To focus on the development of a local sexual health service model that includes Level 3 services, 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 would be to develop and coordinate an integrated system of sexual health services. However, the difference is that in this option, local services would be independent of the Pan-London on-line portal and the wider network of services provided across London.
- 3.21 As an open access service, there is an established arrangement across the Country for cross-charging for GUM. Due to the confidential and sensitive nature of this service, many residents may choose to access GUM services outside their borough of residence; for convenience they may opt for services closer to work or where they socialise.

Brent context

- 3.22 Fifty eight (58%) of attendances in 2014/15 at Brent GUM clinics are by Brent residents (the remaining 42% are non residents of Brent). This includes visits by Brent residents to Northwick Park Hospital, accounting for 14.8% of patients residing in Brent. A high proportion of GUM visits by Brent residents are also made to services outside of the borough. Most notably, 20.7% of the attendances are made to St Mary's hospital; and 6.1% to Royal Free Hospital. Brent residents also attend Central London with 8.8% of attendances at Deane Street in Soho, and 5.9% at Mortimer Market in Bloomsbury.
- 3.23 A local GUM service is provided by London North West Healthcare Trust at Central Middlesex Hospital, Northwick Park Hospital and Ealing Hospital. In 2014/15, there were 39,306 new attendances by Brent residents at GUM clinics. There were 9,066 follow-up attendances.
- 3.24 Contraception is widely available and free of charge from: general practices, Contraceptive and sexual Health services (CaSH), young person's clinics, NHS walk-in centres (emergency contraception only), some GUM clinics (emergency contraception and male condoms) and some pharmacists under a

Patient Group Direction (emergency contraception). In 2014 -15, there were 17,900 attendances by Brent residents at CASH clinics.

- 3.26 For option 3 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 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 continue to prefer to access these services in a central location.

Background

- 3.27 The pan London Sexual Health Transformation Project 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.
- 3.28 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, 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 participating councils achieved a cost avoidance of £2.6m (9.1%) in 13/14, and £2.5m (6.5%) in 14/15.
- 3.29 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 28 councils involved namely Hounslow, Richmond, Havering, Bromley, Bexley and Kingston have now joined the LSHTP.

3.30 The focus of the LSTP work has been on GUM services which are 'payment per unit of activity' rather than Contraception and Sexual Health (CaSH) services which operate under block contracts.

3.31 Councils are responsible for providing 'open access' services for the diagnosis and treatment of Sexually Transmitted Infections (STIs), 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 General Medical Services ("GMS") contract, or for terminations of pregnancy. They (Local Authorities) 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.

Current Situation

3.32 London has the highest rates of Sexually Transmitted Infections (STIs) 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 STIs than other groups.

3.33 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.

3.34 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 LSHTP 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.

3.35 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.

3.3 Why a change is needed

3.3.1 London context

To assess the current state of GUM services in London, the project team has undertaken the following tasks: 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.

3.3.2 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 (STIs) 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 10% to 25% is required to ensure the services are sustainable.

3.3.3 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 councils is needed to deliver the level of change required and to commission these services more effectively to ensure robust quality and financial monitoring.

3.3.4 **Brent Context**

In Brent as in many places, the sexual health and contraceptive services have been commissioned and delivered as separate services. Sexual ill health and need for contraceptive services are related issues, both from the client's perspective and the borough's services. Separate services result in much duplication, financial inefficiencies, as well as inconvenient patient experience. Sexual ill health is not distributed equally in Brent, and there are higher disease burdens on young adults, teenagers, black and minority ethnic groups, and Men who have sex with Men. There are also unequal distribution of teenage conceptions and abortions.

3.3.5 An integrated sexual health service model aims to improve sexual health by facilitating easy access to services through a combined service. This ensures that clients are offered the most appropriate intervention, if treatment is

required then offered at the most appropriate place, and if a service visit is needed, one with the most appropriate skill mix.

- 3.3.6 There is evidence elsewhere that clients accessing GUM services are often not on contraception and clients attending contraceptive services are not having their needs for GUM services addressed. An integrated model will help to address this
- 3.3.7 Improved pathways will occur as all clients will be appropriately referred to specialist and outreach GUM and CASH services as well as related services such as drugs and alcohol. Improved pathways can also occur due to the presence of IT system that supports an integrated service.
- 3.3.8 Appropriate health promotion and screening services which are not currently coordinated can be delivered based on patient need rather than historic models of provision.
- 3.3.9 Duplication of clinics can be avoided and availability of services increased for example contraceptive services both offering specialist LARC clinics at the same time.
- 3.3.10 The improved staff mix with an integrated service and dually trained staff can improve the resilience of the system and avoid clinic closures as well as modern pathways for staff development. It will also improve and rationalise patient flows in services.
- 3.3.11 It reduces duplication of services, allows for extended opening hours, and allows for confidential, high quality client focussed service delivery while addressing the sexual health inequalities.
- 3.3.12 The commissioning and provision of an integrated service model is supported by professional guidance from FSRH, BASHH, BHIVA, MEDFASH, RCOG and NICE². It is also supported by Department of Health and Public Health England.

3.4 Procurement Approach

- 3.4.1 The next phase of the project is for the collaborating boroughs to proceed to the re-procurement of these services, with a view to have new contracts starting in April 2017.
- 3.4.2 Following the procurement outcome, and in recognition of the boroughs' interdependencies and the existence of similar interdependencies with all major GUM providers, coupled with a long term strategic commissioning point of view, the collaborating councils will consider the development of a single commissioning unit either hosted by a LA or commissioned from a specialist

² See Appendix A for Definitions, Glossary of Terms

commissioning organisation. This service will provide oversight of the system to ensure it works and delivers optimally.

3.4.3 **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;
- Partner Notification; and
- Signposting / Patient Direction and where possible Appointments (Booking system) (dependent on ability to interface with existing clinic systems).

3.4.4 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 that 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).

3.4.5 In particular, there are only a few examples of joined up partner notification systems and none of the current providers of home sampling services have proven competence in this area. It is therefore proposed that providers will be awarded lots as determined by the procurement process and evaluation model, with the 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.

3.4.6 Prior engagement with providers proved that delivering clinically effective and cost effective partner notification are key challenges to sexual health service providers. The use of technology has meant individuals can access their results in ‘real time’ and pass information on to partners via instant messaging, immediately ascertaining whether a partner’s testing and treatment is problematic.

3.4.7 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.

3.4.8 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 consumer of staff time. By having a shared database/system for partner notification, the staff time that is used to validate patients’ access and treatment 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. We consider that such a system would offer good value representing between 0.6% and 1.2% of the total contract value.

- 3.4.9 It is therefore proposed to carry out a concurrent Pan-London Online Procurement and award contracts for a minimum term of 5 years (in alignment with the GUM procurement). This will ensure that providers can focus on the clinical aspects of the service requirement necessary to deliver transformed services.
- 3.4.10 Officers are seeking the relevant recommendation to enable the Council to participate in the proposed Pan-London web-based 'front end' procurement within this report.
- 3.4.11 The proposed initial contract term of the Pan-London Online Procurement is envisaged to slightly precede the integrated Sexual Health Service procurement i.e. the North-West London outer regional proposed tender. The aim however is for the outcome to be available for the main stage of Sexual Health procurement (i.e. the negotiation stage of the Competitive Procedure with Negotiation (CPN)) estimated to take place around April – June 2016). The actual time that the 'front end portal' will go live in each borough is likely to vary and it should be noted that the self-testing element will only be switched on as each borough determines it's readiness (i.e. has procured local services). Subject to Para. 3.4.9 above, an estimate of the Pan-London Online contract(s) term will be in the region of 6 years, estimating for the 'front end' to commence 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 proposed Sexual Health procurement contract term stated in paragraph 4.10.

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

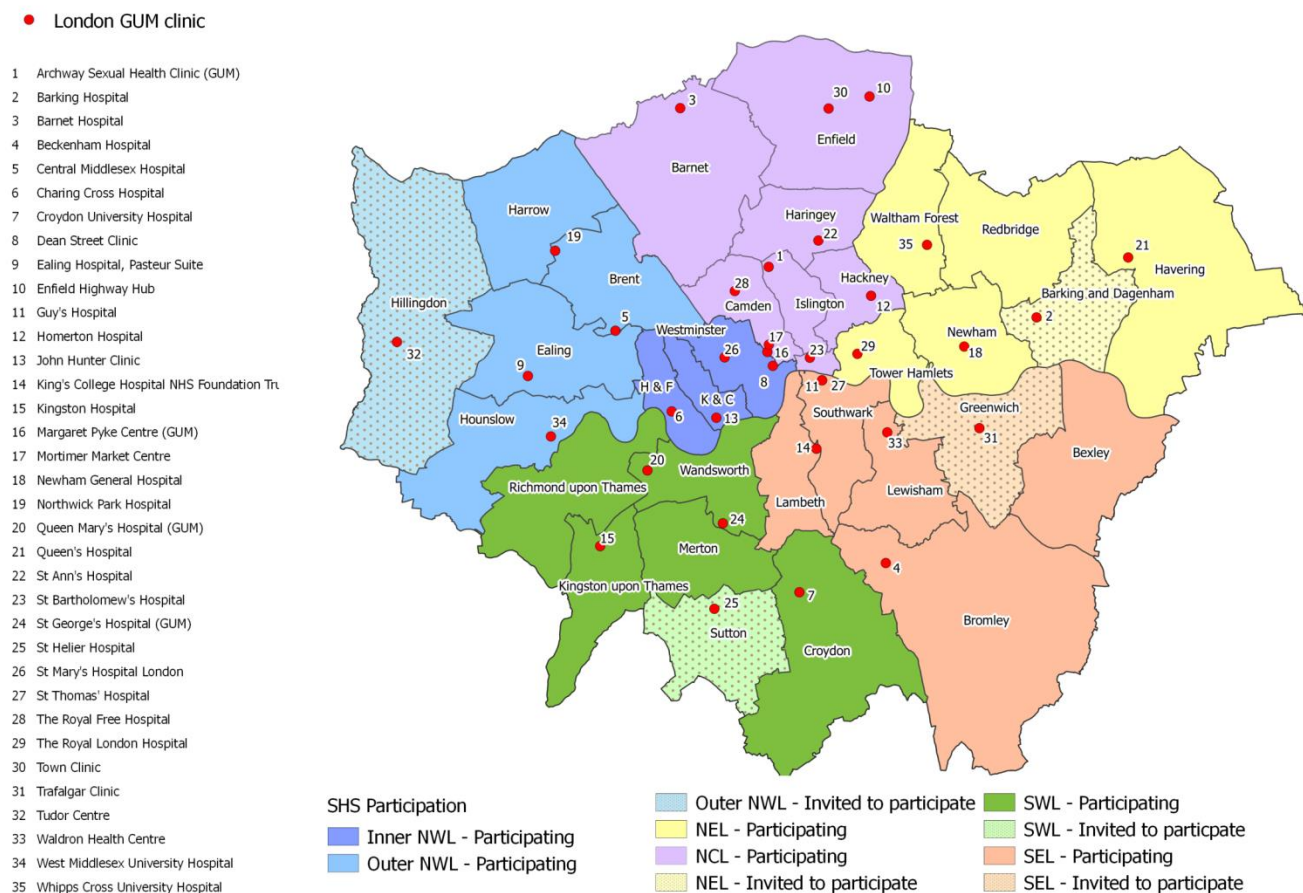
- 3.4.12 It is recommended that GUM and CaSH are procured on a geographical 'lots' basis across London. The primary reason for this is that it was identified through the market engagement exercise that no one bidder has the capability or capacity to be able to provide all sexual health services across London. The proposal is to divide the London region into sub regions for the procurement of GUM and CaSH services.

- 3.4.13 Another reason is the considerable work undertaken in mapping patients' current movements 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 3.22 – 3.26 for patient flow data for Brent.
- 3.4.14 Furthermore, as stated in paragraph 3.8 consideration should be taken to the termination notice period and the effect of any contract extension.
- 3.4.15 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).

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 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. 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 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



3.4.16 Officers are seeking the relevant recommendation for the Council to participate in the North West London (outer region) procurement for an integrated sexual health service.

4.0 Procurement Timetable

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 routes 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.

4.2 However, the CPN process allows the organisation to work with interested parties to design/establish 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 a greater, integrated and improved access service to residents. It should be noted that the grounds for using CPN are harmonised with the grounds permitting use of the competitive dialogue procedure.

- 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.
- 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 negotiation 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 complex 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, (pharmacies and GPs, especially when the service is high volume and less complex/risk – asymptomatic).
- 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 3 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 for boroughs;
- iv. London councils have excellent oversight of service quality; and
- v. Service costs are reduced and optimum quality services can be maintained in light of significant pressures on budgets.

4.6 The Sexual Health indicative procurement project timetable is as follows:

Competitive Procedure with Negotiation	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, CLO and CFO consultation	26-Sep-16	30-Sep-16
Draft Award Notification Letters	26-Sep-16	30-Sep-16
Notification & 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

Current Contract Values

- 4.7 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.
- 4.8 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 the 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.

- 4.9 The existing contract for GUM will expire on 31st March 2016 and officers have obtained Cabinet approval to award a further 1 year contract for 16/17 which, shall expire on 31st March 2017. The CaSH Services contract was previously procured and the initial contract term will expire on 31st March 2017 as the view was taken to realign with the collaborative procurement. The proposed North West (Outer region) Procurement will include both services. Members should note that Brent has the ability to extend its existing CaSH contractual arrangement until March 2019.
- 4.10 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.
- 4.11 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.
- 4.12 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 GUM activity only, they do not include block contracts for Contraception and Sexual Health (CaSH)
- 4.13 For Brent, based on current spend, the estimated aggregate value of the proposed GUM contract for 5 years is in the region of (£23.1 million) plus 4 years (£18.8 million.) = £41.9 million. All the above figures are subject to funding.
- 4.14 The above estimates are based on the same principles as set out in 4.12
- 4.15 The current annual CaSH contract value for Brent is £900,000.
- 4.16 The current annual Primary Care value for Brent is:

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- Chlamydia Screening Payments 14/15 to GPs £24,232
 - IUCD Payments 14/15 to GPs £50,898
 - EHC Payments to Pharmacies £5,226

4.17 The current annual Chlamydia Screening contract value for Brent is £252,000.

4.18 It should be noted that the above estimates are based on current spend on separate contracts and are therefore 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.

4.19 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.

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

4.20 **Brent Sexual Health Service Performance**

A brief snap shot of the local epidemiology indicates key priority areas and groups:

- There is a relationship between STIs and deprivation in Brent; the NW10 postcode has the highest volume of STIs in Brent and these tend to be concentrated in the areas of highest deprivation.
- In 2011, 70% of the borough's diagnosed STIs were in the first and second most deprived of the Lower Super Output Areas (LSOA's)
- In 2014, the rate of new STIs diagnosed in Brent was significantly higher than the England average. Rates of Syphilis and Gonorrhoea are lower than the London average but significantly above the England average
- Young people between 15 and 24 years old experience the highest rates of STIs. In Brent, 45% of diagnoses of acute STIs were in 15 to 24 years old young adults (figures reported in LB Brent Sexual Health Needs Assessment and Service Review, 2013).
- The number and proportion of acute STIs diagnosed in GUM clinics by ethnic group is shown in the table below.

Ethnic group	Number	%
White	1,331	34.5
Black or Black British	1,785	46.2
Asian or Asian British	339	8.8
Mixed	183	4.7
Other Ethnic groups	156	4
Not specified	69	1.8

Source: LB Brent Sexual Health Needs Assessment and Service Review, 2013

- Between 2011 and 2013, 42.7% of adults were presenting with HIV at a late stage of infection. This was similar to the England average, which was 45%.
- Certain groups such as men who have sex with men (MSM) are at an increased risk of poor sexual health outcomes. The uptake of HIV testing amongst MSM measured in GUM clinics in Brent was 95.6% in 2014. This was slightly higher than the England average (94.5%) and London average (95%). However, there was a slight decrease in uptake in all the above areas between 2013 and 2014.
- The under 18 conception rate in Brent has fallen in recent years. In 2013, approximately 18 females conceived for every 1,000 females aged 15 to 17 years. This was lower than both the England and London average rates.
- In Brent, 12 girls aged under 18 years had an abortion for every 1,000 females within this age group in 2013. This was similar to the England rate which was 11.7 per 1,000 women aged under 18 years. The London average rate was slightly higher at 14.
- GP prescription rates for long acting reversible contraceptives in Brent were significantly lower than the England average in 2013. In Brent the rate was 16.6 per 1,000 of the resident female population aged 15 to 44 years compared to 52.7 in England.

4.21 Detailed performance measures and monitoring arrangements will be defined later, once the collaborative commissioning arrangements are in place.

4.3 Environmental Implications

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.

4.4 Risk Management Implications

- 4.4.1 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.
- 4.4.2 It is important to note that service transformation and behaviour change may require clinic relocation, 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.
- 4.4.3 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.
- 4.4.4 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.
- 4.4.5 On the basis of a collaboration across 22 councils (now 28) London boroughs, it is estimated that a pan-London procurement would be for services of a value between £0.5 billion for an initial 5 year contract, and £1billion for the 9 year contract, which included 4 years (2+2) extension. Whilst sexual health services fall under the 'light touch' regime in the Public Contract Regulations 2015, the anticipated value of the procurement sum is considerably in excess of the threshold of €750k (approximately £625k). Given also the attention that this procurement will be given, it is recommended that the full OJEU process be adopted to ensure that proper processes are followed throughout each stage of the procurement.
- 4.4.6 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).

- 4.4.7 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 once authorised by Cabinets to progress with the collaboration. Officers will need to ensure appropriate legal, financial and other relevant advice is obtained in establishing suitable governance and professional project resources. 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 mitigated.

5.0 Legal Implications

- 5.1 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.
- 5.2 The procurement exercise for the pan-London collaborative Sexual Health Transformation ('front – end' web portal) will be subject to the Public Contract Regulations 2015 (the "Regulations"). Ordinarily, such procurement would need to comply with Brent's own Contract Standing Orders ("CSOs"); however Officers have indicated that a Lead Authority will be identified from the partner authorities to undertake the full procurement process on behalf of the participating London boroughs. Therefore, Officers have been advised to seek Member's approval to grant an exemption from Brent's CSOs to the identified lead authority so as to enable the effective procurement of the web-based portal to be procured within the projected timescales. It is not clear presently what the contractual structure of the pan-London collaborative procurement will take, therefore it will be imperative for Officers to seek advice from Legal Services as the procurement develops. Should Members be minded to grant an exemption from CSOs for this proposed procurement then the Lead Authority will need to ensure that it sets out the pre-tender considerations (i.e. evaluation criteria and award criteria) and adheres to its obligations, as Contracting Authority under the Regulations.
- 5.3 As referred to in Para. 4.4.5 the procurement of a GUM, CaSH and Primary Care service falls under the 'light touch regime' under the Regulations;

however due to the potential value of the services exceeding the EU threshold a full OJEU tender exercise must be undertaken. Officers have indicated that the London Borough of Harrow will act as the Lead Authority for the North West London (Outer region) collaborative procurement exercise and will procure the service on behalf of Brent and Ealing. As such, Officers are seeking Member approval to grant an exemption from CSOs to enable the London Borough of Harrow to effectively procure the proposed integrated sexual health services on behalf of the partner boroughs. Brent Officers will work with Harrow to ensure the council's requirements are adequately covered in relation to any pre-tender considerations. It is proposed to use one of the new processes (introduced by the Regulations) Competitive Procedure with Negotiation throughout the tendering exercise, which will ensure good quality services are procured at a competitive price. However, officers must ensure that a specification stating the council's service requirements is advertised which, sets out which parts of those requirements are minimum requirements that all prospective tenderers are required to meet. In addition, by using this process, the contracting authority leading the procurement must specify the contract award criteria and provided sufficiently precise information to enable prospective tenderers to identify the nature and scope of the procurement so as to enable them to decide on whether or not to request to participate in the tender exercise.

- 5.4 Moreover, officers are further seeking Member approval to grant delegated authority to the Director of Public Health in consultation with legal and finance to enter into cross-charging arrangements, review the collaborative tender process and award subsequent contracts for both the pan-London web-based portal and the sub-regional integrated sexual health services. Members are empowered in the Constitution to grant such delegations and Officers have set out the reasons behind requesting such delegations within the body of this report.

6.0 Financial Implications

- 6.1 In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget.
- 6.2 Brent's initial grant allocation for 2016/17 totals £22.530m and includes the annual allocation for health visiting. The public health grant will stay ringfenced in 2016/17 and 2017/18, and there has been a move to consult on fully funding the councils public health spending from retained business rate receipts. In 2015-2016 an in year cut of £200m nationally has been agreed. This equates to £1.3m for Brent.
- 6.3 On the 25th Nov 2015 the Chancellor has announced additional savings against the public health grant in the autumn 2015 spending review. There will be a national average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of national savings that were announced earlier this year. From the baseline

of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

6.4 Across London, Councils currently spend approx. £115m per annum on GUM services, excluding contraception, and this is predicted to increase to £124.5m by 2022 if LAs 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 is likely to be a conservative estimate as changes in behaviour is also driving demand.

6.5 Whilst the ring-fence is maintained, any efficiencies achieved on public health expenditure (including that delivered through procurement programmes) will 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.

Efficiencies

6.7 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 i.e. online triage which will enable self-sampling,
- 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

6.8 It is difficult at this stage to quantify the level of further GUM savings which may be delivered through an integrated service, however, these are expected to be in the region of 10-25% with the potential to 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.

6.9 Subject to the procurement process, the newly procured contracts are expected to start from April 2017.

6.10 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, taking in consideration that these are mandatory services.

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

7.0 Diversity implications

- 7.1 The Council must comply with the Equality Act 2010 and the Public Sector Equality Duty in the provision of Public Health services and adhere to the NHS Constitution when making decisions affecting the delivery of public health in its area. The needs assessment has highlighted that some groups with protected characteristics, such as young people aged 16-25, men who have sex with men, and Black African/Caribbean/British groups, suffer a higher burden of rate of Sexually Transmitted Infections. When procuring the service we therefore must fully consider the needs of affected groups, minimise any potential negative impact and optimise positive outcomes for these groups.
- 7.2 It is intended that the proposed procurement will deliver better value for money whilst achieving improved access, better outcomes for services users and the whole community. The service specification will incorporate relevant Equality and Diversity requirements and monitoring arrangements to ensure that the intended outcomes are achieved.

A full Equalities Impact Assessment has been carried out and is included in **Appendix 4**.

8.0 Staffing/Accommodation Implications

- 8.1 The Public Health services are currently provided by a number of external contractors, and there are no implications for Council staff or Council accommodation arising from this procurement.
- 8.2 On a re-tender of any of the services referred to in this report, where an incumbent provider is not successfully awarded a new contract, the Transfer of Employment (Protection of Employment) Regulations 2006, ("TUPE") is likely to apply. This is to enable the transfer of employees (who spend all or most of their working time on the activities taken over by the new provider) from the current to the new provider.

9.0 Public Services (Social Value) Act 2012

- 9.1 Since 31st January 2013 the council, (in common with all public authorities subject to the EU Regulations), has been under a duty pursuant to the Public Services (Social Value) Act 2012 to consider how the services being procured might improve the economic, social and environmental well-being of its area; and how, in conducting the procurement process, the Council might act with a view to securing that improvement, and whether the council should undertake

consultation. This duty applies to the procurement of the proposed contract as the light touch regime over the threshold for application of the EU Regulations are subject to the requirements of the Public Services (Social Value) Act 2012.

- 9.2 The services being procured have as their primary aim the improvement of the social and economic wellbeing of some of the most disadvantaged groups in Brent. Users are regularly consulted to ensure the services meet their needs, and the views of users will be taken into account in procuring services.
- 9.3 There is a limited market (for some services a very limited market) for the delivery of these services; however, officers will endeavour to describe the scope of services in such a way as to further meet the requirements of the Act during the procurement process.
- 9.4 All contractors will be required to pay London Living Wage for all Public Health services contracts.

Background Papers

- Award of Contracts for Public Health Services. Cabinet 15th December 2014.
- Update on Public Health Service Contracts. Cabinet 15th September 2014.
- Authority to Tender Public Health Contracts. Executive 13th January 2014.

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Appendices

Appendix A	Project definitions for elements of STI management at Levels 1, 2 and 3
Appendix B	Summary of commissioning responsibility
Appendix C	Glossary of Terms
Appendix D	Equalities Impact Assessment

Appendix A - Project definitions for elements of STI management at Levels 1, 2 and 3

The following lists comprise elements of STI management that are appropriate at various levels of service provision. They are drawn from the three Levels (1, 2 and 3) defined in the National strategy for sexual health and HIV, published by the DH in 2001, and have been updated by this project to take account of modern service provision in 2009. They look specifically at STIs and related conditions and do not include elements of contraceptive and reproductive healthcare that may also be provided at these levels.

The elements of care listed below are not to be considered as minimum requirements, but rather as maximum specifications, for each service level. Care pathways should be in place for onward referral if the clinical condition is beyond the scope or competence of the original service. To ensure optimum care for service users, it is recommended that there should be formal links between services providing STI management at Levels 1 or 2 and those at Level 3 as set out in Standard 7.

Level 1

Sexual history-taking and risk assessment

including assessment of need for emergency contraception and HIV post-exposure prophylaxis following sexual exposure (PEPSE)

Signposting to appropriate sexual health services

Chlamydia screening

Opportunistic screening for genital chlamydia in asymptomatic males and females under the age of 25

Asymptomatic STI screening and treatment of asymptomatic infections (except treatment for syphilis) in men (excluding MSM)* and women

Partner notification of STIs or onward referral for partner notification

HIV testing

including appropriate pre-test discussion and giving results

Point of care HIV testing

Rapid result HIV testing using a validated test (with confirmation of positive results or referral for confirmation)

Screening and vaccination for hepatitis B

Appropriate screening and vaccination for hepatitis B in at-risk groups

Sexual health promotion

Provision of verbal and written sexual health promotion information

Condom distribution

Provision of condoms for safer sex

Psychosexual problems

Assessment and referral for psychosexual problems

Level 2

Incorporates Level 1 plus:

**STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)*
and women excluding:**

- men with dysuria and/or genital discharge**
- symptoms at extra-genital sites, eg rectal or pharyngeal
- pregnant women
- genital ulceration other than uncomplicated genital herpes

Level 3

Incorporates Levels 1 and 2 plus:

STI testing and treatment of MSM*

STI testing and treatment of men with dysuria and genital discharge**

Testing and treatment of STIs at extra-genital sites

STIs with complications, with or without symptoms

STIs in pregnant women

Recurrent conditions

Recurrent or recalcitrant STIs and related conditions

Management of syphilis and blood borne viruses

including the management of syphilis at all stages of infection

Tropical STIs

Specialist HIV treatment and care

Provision and follow up of HIV post exposure prophylaxis (PEP)***
both sexual and occupational

Appendix B – Summary of commissioning responsibility

Local authorities' commission

Comprehensive sexual health services. These include:

- 1. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)*
- 2. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV*
- 3. Sexual health aspects of psychosexual counselling*
- 4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies*

Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:

- 1. HIV social care*
- 2. Wider support for teenage parents*

Clinical commissioning groups commission

- 1. Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see "NHS England commissions")*
- 2. Female sterilisation*
- 3. Vasectomy (male sterilisation)*
- 4. Non-sexual health elements of psychosexual health services*
- 5. Contraception primarily for gynaecological (non-contraceptive) purposes*

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6. *HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)*

NHS England commissions

1. *Contraceptive services provided as an “additional service” under the GP contract*
2. *HIV treatment and care services for adults and children, and cost of all antiretroviral treatment*
3. *Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of “essential services” under the GP contract (ie not part of public health commissioned services, but relating to the individual’s care)*
4. *HIV testing when clinically indicated in other NHS England-commissioned services*
5. *All sexual health elements of healthcare in secure and detained settings*
6. *Sexual assault referral centres*
7. *Cervical screening in a range of settings*
8. *HPV immunisation programme*
9. *Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks*
10. *NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B*

Reference:

Public Health England, Making it Work, September 2014

Appendix C - Glossary of Terms

A&E	Accident & Emergency
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
CaSH	Contraception and Sexual Health Service
CCG	Clinical Commissioning Group
DH	Department of Health
FA	First Attendance
FU	Follow Up
FSRH	Faculty of Sexual and Reproductive Healthcare
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
LA	Local Authority
LARC	Long Acting Reversible Contraception
LSHTP	London Sexual Health Transformation Project
MEDFASH	Medical Foundation for HIV & Sexual Health
MSM	Men who have Sex with Men
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
OJEU	Official Journal of European Union
PEP	Post Exposure Prophylaxis
PEPSE	Post Exposure Prophylaxis following Sexual Exposure
PH	Public Health
PHE	Public Health England
PIN	Prior Information Notice
RCOG	Royal College of Obstetricians and Gynaecologists
SH	Sexual Health
STI	Sexually Transmitted Infection