For General Release

REPORT TO:	CABINET 20 October 2015
AGENDA ITEM:	**10**
SUBJECT:	**Integrated Sexual Health Service Commissioning Arrangements**
LEAD OFFICER:	**Mike Robinson, Director of Public Health**
CABINET MEMBER:	**Cllr Woodley, Cabinet Member for Families, Health and Social Care** **Cllr Hall, Cabinet Member for Finance and Treasury**
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT

The proposed approach seeks to support the successful achievement of the following outcomes in Ambition Priority Two (Independence) of Croydon's Corporate Plan 2015-18:

- Early Intervention:
  - **Promise 21**: Provide high quality information, advice and guidance to support people living independent and healthier lives and improve their overall well-being
- Longer, healthier lives:
  - **Promise 27**: Work with partners to provide more integrated health, care and support in local communities.
- Safeguarding:
  - **Promise 33**: Work with our partners to ensure children and vulnerable adults are protected from harm, abuse and exploitation through effective and efficient safeguarding processes and procedures.
- Domestic abuse and sexual violence:
  - **Promise 35**: Work with partners to change attitudes in the community to domestic abuse and sexual violence, and child sexual exploitation.

Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (the 2013 Regulations), the Council is required to provide or make arrangements to secure provision of open access sexual health services in its area. This includes:

- Advice on, and reasonable access to, a broad range of contraceptive substances and appliances;
- Advice on preventing unintended pregnancy;
- Services for preventing the spread of sexually transmitted infections;
- Services for treating, testing and caring for people with such infections; and
- Services for notifying sexual partners of people with such infections.

AMBITIOUS FOR CROYDON & WHY ARE WE DOING THIS:

Provision of these services will contribute to achievement of the following priorities:

Croydon Challenge:

- The services will be redesigned in order to be more streamlined for patients. This will be a more effective way of achieving the outcomes of the service while also delivering efficiencies of at least 14% over three years.

The proposed approach will also contribute to the following priorities within the Council's Independence Strategy:

- Priority 2 – Enable residents to make informed choices about how to meet their needs, and how to live healthy lives, through the provision of high quality information, advice and guidance.
- Priority 4 – Empower people to resolve issues early through the provision of joined up assessment and support.
    - We will work with partners to provide more integrated health, care and support in local communities.
- Priority 5 – Enable children and adults to maximise their independence and ensure they are safe from harm through the provision of high quality specialist services.

Public Health Outcomes Framework (PHOF):

- Reducing teenage pregnancy (PHOF Indicator 2.04)
- Reducing chlamydia among 15-24 year olds (PHOF Indicator 3.02ii)
- Reducing the number of people diagnosed with HIV at a late stage of infection (PHOF Indicator 3.04)
- Violent crime (including sexual violence) (PHOF Indicator 1.12)
- Children in poverty (PHOF Indicator 1.01i)
- 16-18 year olds not in education employment or training (PHOF Indicator 1.05)

Additional corporate priorities:

- Reducing repeat terminations

FINANCIAL IMPACT

The budget for sexual health services included under this proposal is up to £3.459m in 2016/17. The projected spend from 2017/18 is no more than £3.279m per annum. The cost of this service is met from the Public Health Grant.

Through the implementation of this proposal, efficiencies totalling 9% in 2016/17 and 14% from 2017/18 are anticipated compared to the 2014/15 budget for the sexual services currently provided by Croydon Health Services prior to redesign.

KEY DECISION REFERENCE NO.: 20/15/CAB

The Leader of the Council has delegated to the Cabinet the power to make the decisions set out in the recommendations below

RECOMMENDATIONS

The Cabinet is recommended to:

1.1 Approve the arrangements for the provision of Integrated Sexual Health Services by way of an agreement between Croydon Council and Croydon Health Services under Section 75 of the National Health Service Act 2006 for the provision of Integrated Sexual Health Services from April 2016 for an initial term of three years, with a further extension period of up to two years.

1.2 Consider the Council's public sector equalities duty and the analysis at paragraph 8 of this report and agree the mitigating actions identified in para.8 which will be secured through the specification for services under the s.75 agreement.

1.3 Agree that, for the reasons detailed in section 3.8 of the report, the Director of Public Health be given delegated authority, in consultation with the Cabinet Member for Families, Health and Social Care and the Cabinet Member for Finance and Treasury to make any amendments to the Integrated Sexual Health Service Commissioning Arrangements considered necessary after the decision has been made.

1.4 Note that where any amendments are made under this delegation, the amended Integrated Sexual Health Service Commissioning Arrangements will be published on the Council's website no later than 31 December 2015.

1. EXECUTIVE SUMMARY

1.1. The main sexual health services in Croydon are currently provided by Croydon Health Services (CHS) and Terrence Higgins Trust (THT). These contracts end on 31 March 2016. This report determines that new arrangements will be in place from 1 April 2016 to ensure continuity of provision.

1.2. The Council is mandated to provide open access sexual health services under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 ('the 2013 Regulations'). In addition, aligned to the Independence priority, the proposed new sexual health services model will directly contribute to delivering on the promises to "provide high quality information, advice and guidance to support people living independent and healthier lives and improve their overall well-being" and to "work with partners to provide more integrated health, care and support in local communities".

1.3. CHS have, since February 2015, been developing and implementing a redesigned model for sexual health services in Croydon that delivers integrated contraception and sexually transmitted infection provision and has a greater focus on communities that experience poorer sexual health outcomes, while

also preparing for a reduction in budget for the integrated sexual health services from up to £3.639m per annum in 2015/16 to up to £3.279m per annum from 2017/18.

1.4. This report proposes the future arrangement for commissioning of these services be by way of an agreement between Croydon Council and Croydon Health Services under Section 75 of the National Health Service Act 2006 (NHS Act (2006)) to deliver the redesigned integrated sexual health provision from 1 April 2016.

2. DETAIL

2.1. Background

3.1.1 Croydon has a significantly higher rate of all new sexually transmitted infection (STI) diagnoses than England. Although Chlamydia detection rates in 15-24 year olds are also significantly higher than London, rates of other STIs are significantly lower than the London average (Table 1). Rates of all STI diagnoses have remained fairly stable in Croydon since 2012; however, rates of gonorrhoea have increased significantly since 2009.

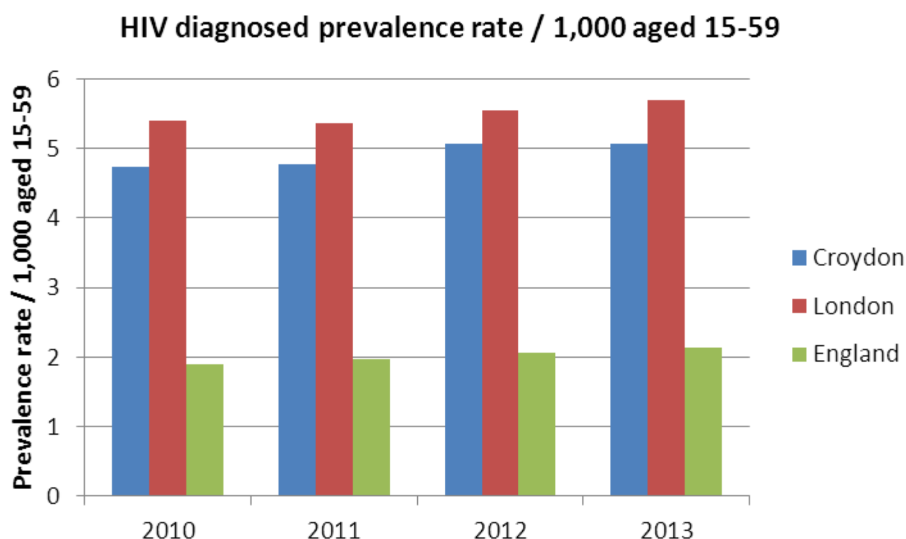
Table 1: STI diagnosis rates in Croydon, London and England (2014)

Indicator	Croydon	London	England
New STI diagnosis rate / 100,000	1,231	1,347	797
All new STI diagnoses (excl. Chlamydia aged <25) / 100,000	1,321	1,534	829
Chlamydia detection rate / 100,000 aged 15-24	2,739	2,178	2,012
Syphilis diagnosis rate / 100,000	10.5	27.4	7.8
Gonorrhoea diagnosis rate / 100,000	152.1	190.5	63.3
Genital warts diagnosis rate / 100,000	127.2	161.3	128.4
Genital herpes diagnosis rate / 100,000	61.7	88.1	57.8

Rates of chlamydia are likely to be higher due to a combination of good coverage of testing (28% of young people aged 15-24 were tested in 2014, similar to London (27.9%) but higher than the England average of 24.3%), good targeting of testing towards those at highest risk and a higher incidence of Chlamydia in Croydon.

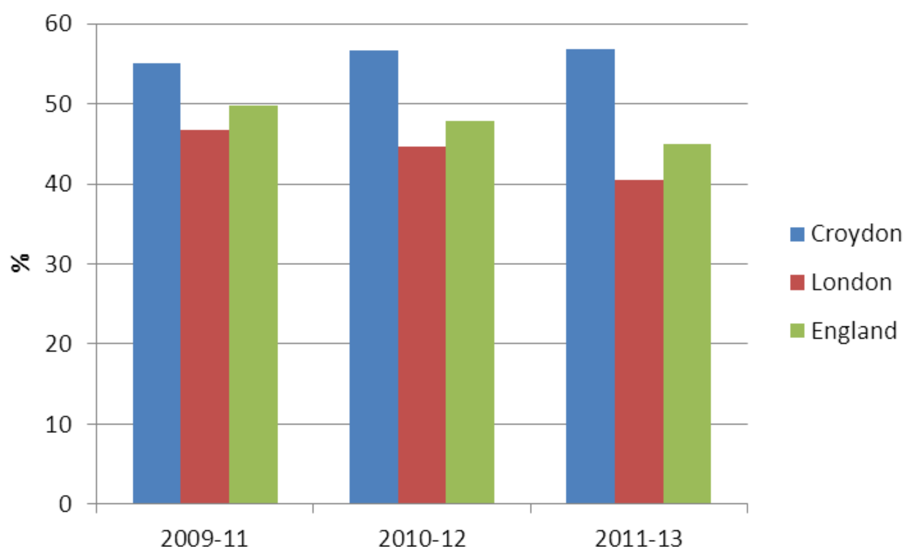
3.1.2 The prevalence rate of diagnosed HIV is high in Croydon (5.07 per 1,000 aged 15-59) and has been increasing slowly since 2010. This rate of increase is lower than England but higher than London. The actual rate in Croydon is lower than the London average (5.69 per 1,000; range across London boroughs: 1.82-14.70 per 1,000) and higher than the England average (2.14 per 1,000) (Figure 1).

Figure 1: HIV diagnosed prevalence rate / 1,000 aged 15-59



In addition, a significantly higher proportion of people diagnosed with HIV in Croydon in 2011-13 (56.8%) were diagnosed after the point at which treatment should have begun compared to both London and England (Figure 2). The high rates of late diagnosis in Croydon are likely to be due to a combination of factors, including the high proportion of the local population who are Black African (due to the higher prevalence in this group), good rates of testing high risk residents, missed opportunities for early diagnosis in some healthcare settings, and relatively high numbers of new arrivals to Croydon from areas of high HIV prevalence, including sub-Saharan Africa.

Figure 2: HIV late diagnosis (%)

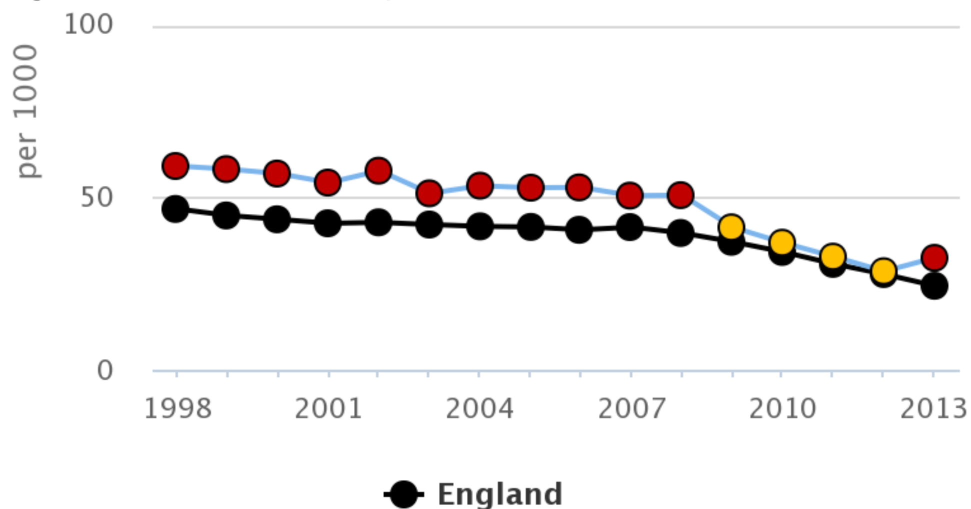


The relatively high rates of diagnosed HIV suggest Croydon is performing well in identifying undiagnosed HIV cases in the population; testing coverage in Croydon's GUM service is 81.4% (uptake of the HIV test in people attending), compared to 75.3% and 68.9% in London and England respectively. In addition, efforts to better target HIV testing in Croydon to high risk populations are likely to be contributing to the high rates of late diagnosis, as undiagnosed people who have been living with HIV for some time are now being identified. In the longer-term, this work and prevention work should reduce late and new HIV diagnosis rates.

3.1.3 Despite significant improvements in the under-18 conception rate since 2008, the under-18 conception rate is now significantly higher in Croydon than the London and England averages following a rise in 2013 (Figure 3). In Q2 of 2014, the under-18 conception rate (actual) was 29.9 per 1000 girls aged 15-17 years of age and equated to 53 conceptions. The rolling quarterly average conception rate for Q2-2014 was 33.4 per 1000 girls aged 15-17 years of age. This is unchanged from the rolling average in Q1 but, prior to this, the rolling quarterly average data showed consistent increases over the previous five quarters and this trend upwards was statistically significant (ie. we are 95% certain that the rates are increasing rather than this observed increase being a random fluctuation). Reasons for this observation could be changes to the effectiveness of services targeting young people at risk of teenage pregnancy or changes to wider determinants known to be associated with an increase in teenage pregnancy. However, due to the effect that small increases in the number of teenage pregnancies have on the overall picture and the delay in receiving the data for analysis, it is difficult to identify specific reasons for such an increase.

In 2013, Croydon also had the highest rate of repeat abortions among young women aged under 25 of any London Borough (38.7%).

Figure 3: Under 18s conception rate / 1,000



Compared with England benchmark: Better Similar Worse

3.1.4 In 2013/14, rates of pelvic inflammatory disease were significantly higher in Croydon than in London or England. Rates of ectopic pregnancy were also significantly higher in Croydon than in England, although these were not significantly higher than the London average. Sexually transmitted infections such as chlamydia can increase the risk of these conditions, which are likely to present cost pressures to the CCG.

3.1.5 The Joint Strategic Needs Assessment (JSNA), completed in 2010/11, identified a number of groups that experience worse sexual health outcomes including: young people, particularly those being looked after by the local authority, those leaving care, and those not in education, employment or training; younger Black Caribbean, Black African and other Black population groups; men who have sex with men; those who misuse drugs or alcohol; and sex workers.

3.1.6 A local sexual health strategy for Croydon was developed by the Sexual Health and HIV Partnership Board and approved by Cabinet in September 2012 (minutes reference: A98/12). This draws on the needs identified in the JSNA chapter, details the evidence for intervention and makes recommendations for further action. In addition to the overarching strategy, three sub-strategies were approved covering the priority areas of:

- HIV testing;
- Repeat abortions;
- Sexual health promotion and education.

3.1.7 Under the 2013 Regulations, the Council is required to provide or make arrangements to secure provision of open access sexual health services in its area. This includes:

- Advice on, and reasonable access to, a broad range of contraceptive substances and appliances;
- Advice on preventing unintended pregnancy;
- Services for preventing the spread of sexually transmitted infections;
- Services for treating, testing and caring for people with such infections;
- Services for notifying sexual partners of people with such infections.

3.1.8 These services must be available for the benefit of all people present in the local authority's area. The local service arrangements include open access Contraception and Sexual Health (CASH) and Genitourinary Medicine (GUM) services.

3.1.9 The Croydon HIV and Sexual Health Partnership Board identified five main priorities for sexual health that should shape service provision:

- Reducing the rates of late diagnosis of HIV;
- Reducing the rates of teenage pregnancy;
- Reducing repeat abortions;
- Reducing the prevalence of STIs; and
- Locally delivered, community-focused services.

3.1.10 The Council directly awarded a one-year contract to Croydon Health Services (CHS) for these services for 2015/16 using the Public Health Services Standard Contract form. This was intended to maintain statutory service provision during 2015/16, while providing sufficient opportunity for the Council to work with the incumbent provider to address the objectives of integrated services, improved access and increased uptake of services among target groups. In addition, this period provided the opportunity for the Council to develop a detailed plan in respect of its commissioning intentions in the medium term.

3.1.11 The Council directly awarded a 1+1 year contract to Terrence Higgins Trust for the delivery of the Chlamydia Screening Programme from April 2014 which is currently in its one-year extension period. This service is a collaborative arrangement with the other South West London boroughs of Merton, Richmond, Sutton and Wandsworth. The direct award was made on the basis of previous good performance and to allow opportunities for local sexual health service redesign to be considered, particular to consider how each of the boroughs participating in the programme could integrate chlamydia screening into wider sexual health service provision. The one year extension option in the contract was therefore utilised to bring the chlamydia screening and integrated sexual health contracts into the same timeframe so they could be considered together for 1 April 2016 onwards.

3.1.12 The intention of these extensions of previous arrangements was to ensure stabilisation post-transition of sexual health commissioning responsibility to the local authority and to work with the incumbent provider to develop and begin the implementation of a new integrated model for sexual health that has a greater focus on prevention and high risk and vulnerable communities. In addition, this allowed time for public engagement work to be undertaken that is helping to inform the final service configuration.

3.1.13 In addition to contracted services, Croydon Council is obliged to pay for its residents accessing STI testing and treatment services (Genito-Urinary Medicine (GUM)) for which it does not hold contracts. This is because these services are open access and providers are therefore advised to cross-charge the non-host local authority. These open access arrangements allow service users to choose their provider based on location, quality of service and types of services offered. The majority of Croydon residents currently use Croydon

services; however, approximately £1.2m per annum is paid to other GUM providers out of the borough for Croydon residents.

3.1.14 Croydon Council also contracts with GP practices and pharmacies to provide contraception, chlamydia testing and other services at a value of approximately £586,000 per annum. Additional services are commissioned with the voluntary sector to deliver targeted prevention work with certain population groups such as people living with HIV and communities identified with high HIV prevalence and stigma. The combined value of these is approximately £180,000.

3.2. Current service provision (2015/16 contract)

3.2.1. The current contract with CHS is working towards an integrated model for sexual health provision that incorporates previously separate services for contraception provision and the testing and treatment of sexually transmitted infections. This includes:

- Open access provision of testing, treatment and partner notification for sexually transmitted infections;
- A new 'Test & Go' service (in development) for asymptomatic service users who do not have other complex needs;
- All methods of contraception, including Long Acting Reversible Contraception (LARC);
- A domiciliary contraception service for young people, available on referral; and
- Young people's sexual health outreach, providing integrated sexual health and contraception at bespoke clinics in areas of high need, sexual health training to front-line staff working with young people and outreach work with vulnerable young people.

3.2.2. In 2014/15, the CHS-provided GUM service delivered 10,810 first appointments and 4,943 follow-up appointments to Croydon residents. 97% of service users attending for first appointments were offered HIV tests and the service achieved an 87% uptake rate. In addition, 90% of young people aged 15-24 took up the offer of a chlamydia test with the service and the service delivered approximately 45% of all chlamydia screens and identified 60% of all the positive cases diagnosed in the borough in 2014/15. 100% of patients were seen or offered to be seen within 48 hours of first making contact with the service.

3.2.3. In 2014/15, the CaSH service delivered 8,858 appointments (2,623 first appointments and 6,235 follow-ups) to support service users with choosing and maintaining an appropriate method of contraception and providing advice on sexual and reproductive health. 55% of the appointments were for young people aged under 25, which reflects the additional provision targeted at young people, such as the young people's sexual health outreach clinics and the domiciliary contraception service.

3.2.4. The young people's sexual health outreach team deliver 26 training courses to front-line staff, deliver the teenage pregnancy prevention programme to 650 young people each year and see at least 2,000 young people in young people's sexual health outreach clinics located in targeted venues across the borough.

3.2.5. In addition to the service provision above, the service commissioned for 2015/16 required CHS to meet, or demonstrate work towards, a number of commissioning principles for the redesigned service:

- Integrated services (i.e. the provision of STI testing, diagnosis and treatment and contraception being available on one site, at levels which are appropriate to that site, so service users can have all their sexual health and contraception needs met in one visit where appropriate);
- Dual-trained staff to deliver the integrated services;
- Open access services (i.e. individuals from anywhere in the country can access services in Croydon, and Croydon residents will also be able to access services out of the borough);
- A shift from the current hospital-based, consultant-lead provision, to community-focused provision;
- Targeted provision to address areas of high need and individuals and groups with particularly high rates of STIs and unwanted conceptions;
- HIV outreach testing to vulnerable and at risk groups, potentially in partnership;
- Provision of psychosexual services (to be considered in conjunction with the CCG, as the commissioners of non-sexual health elements of psychosexual services);
- Development of a self-care approach, including provision of information, availability of home-sampling;
- Work with clinical colleagues in primary and secondary care to reduce late diagnosis through increased awareness;
- Improved targeting of provision to those most at risk of STIs and unplanned pregnancy, particularly through partnership work with other providers/agencies/departments and outreach into target communities;
- Re-balancing of resources to increase the capacity of the young people's sexual health team and put a greater focus on prevention;
- Provision of training for front line sexual health staff on safeguarding, domestic violence and FGM; and
- Training and skills for front line staff working with particularly vulnerable groups to identify need and proactively signpost patients to relevant services (e.g. sex workers, drug and alcohol users, victims of domestic violence, asylum seekers).

3.2.6. Croydon Health Services have responded to the pace of this challenge and have developed and begin delivering an action plan that will deliver the above principles. This has included the development and initial implementation of a redesigned service model and work to improve the provision of data to commissioners. Throughout this period, CHS have demonstrated their willingness to work in partnership to achieve the best possible outcomes for Croydon within the constraints of the resources available.

3.2.7. The Chlamydia Screening Programme for 15-24 year olds delivered by Terrence Higgins Trust (THT) consists of:

- Responsibility for meeting the target diagnostic rate in the borough;
- Co-ordination of tests carried out by a wide variety of providers, including provision of sample kits, pathology testing for both chlamydia and gonorrhoea, notification of results, partner notification and signposting/referral to treatment providers;

- Outreach programme to encourage testing among young people;
- Training of providers, including GPs and practice nurses, pharmacies, abortion services and other front-line staff; and
- Collation and reporting of data to commissioners and Public Health England.

3.2.8. In 2014/15, THT's work on chlamydia screening (both directly and with partners) identified 491 cases outside of GUM. The targeted outreach programme specifically delivered by THT carried out 610 screens and identified 34 cases of chlamydia. A diagnostic rate of 2,600 per 100,000 15-24 year olds was achieved; this is substantially higher than the national recommended rate of 2,300 per 100,000 but short of the challenging 3,000 per 100,000 target set internally.

3.2.9. The total budget for the CHS services is £3.419m in 2015/16. This budget is 5% less than that for 2014/15 and CHS were tasked to develop a model that, once fully implemented, could operate at 15% less than 2014/15 by 2017/18, while continuing to deliver a high-quality, safe and effective service to achieve the identified outcomes. In addition to this, the budget for the chlamydia screening programme delivered by THT is £220,325.

3.2.10. To address high HIV late diagnosis, Croydon has undertaken a number of substantial projects both with and outside of work with CHS. In particular, the Council has been recognised in several pan-London meetings for the success of its HIV testing week campaign, through which 419 people were tested in 2014, of whom 43% were from highest risk communities and 45% had never tested for HIV before. Croydon has also been recognised by PHE for its timely response to the Do It London campaign to encourage HIV testing. In addition, the work of the Sexual Health Promotion Lead employed by Croydon Council has helped establish trust and strong community links to high risk groups where there is notable HIV stigma. CHS offer consistent access to screening at the GUM clinic and, as part of the re-design, has begun offering HIV testing on request in CaSH. Croydon is also prototyping joint work between the Sexual Health Promotion Lead and CHS to bring CHS staff in close contact with communities reluctant to use the current sexual health service offer.

3.3. Future service provision (April 2016 onwards)

3.3.1. Future service provision is intended to build on the progress made towards delivering the commissioning principles detailed above and will consist of a single, open access, integrated sexual health service delivering contraception provision, STI testing and treatment and outreach and prevention activity to target groups.

3.3.2. A particular focus of the future provision will be on community-focussed services, with an emphasis on prevention and partnership working to improve outcomes. This will be guided by evidence of varying needs in different population groups, both geographically and by non-geographic demographic characteristics. Wherever possible, these services will be developed using the insight of those communities that are to be targeted. Further information on this engagement work is detailed in section 4 of this report.

3.3.3. The aim is to ensure a whole system approach that builds on existing, well-developed relationships and pathways with other services, while further implementing the principles detailed in sections 3.2.1 and 3.2.4 of this report. In particular, this should deliver an increase in the amount of targeted prevention activity undertaken, while building on current good practice around young people's sexual health outreach work, domiciliary contraception provision, high quality GUM and CaSH provision, sexual health services in local pharmacies and existing sexual health promotion work with high risk communities. This will be linked to improved accessibility of services to those most at risk of teenage pregnancy, repeat abortion, STIs and HIV which should, in turn, deliver improved outcomes in these areas for residents of Croydon.

3.3.4. It is considered that the most effective way of achieving these aims is to continue to work with the existing, local provider, Croydon Health Services, and therefore it is proposed that Section 75 of the NHS Act (2006) ('s75 agreement') be utilised through which Croydon Health Services will exercise part of the sexual health services function on behalf of Croydon Council. This will further develop the very positive relationship between Croydon Council and CHS that has been established through the early stages of this redesign work, particularly in the areas of prevention and sexual health promotion.

3.3.5. It is proposed that the chlamydia screening programme, presently provided by the Terrence Higgins Trust under contract to 31st March 2016, be included in the scope of the s75 agreement. This will ensure the integration of this element of provision with the core integrated sexual health service. However, CHS will be free to sub-contract this element of provision via competitive tender should that arrangement be deemed more effective in delivering the required outcomes.

3.3.6. The arrangements and details of the s75 agreement will be finalised by negotiation; for example, the chlamydia screening element of the service may be delivered by CHS in an extension of its current arrangements, or it may be subcontracted to another provider. However, it is proposed that the agreement will include requirements for CHS to continue to deliver the service in line with an agreed service specification and that they will supply performance data and meet key outcomes and performance indicators as at present. In addition, a break clause will be in place that allows termination of the agreement with 6-12 months notice should this become necessary. The exact period will also be agreed by negotiation.

3.3.7. If through negotiation the Council is unable to obtain sufficient confidence that CHS can deliver the outcomes required at the budget detailed in section 5 of this report, then an open or restricted tender route will be re-evaluated and a new approach brought forward for approval through the usual governance routes.

3.3.8. Subject to approval of these recommendations, the following is an indicative timetable:

28 October	Key decision implementation date
29 October – 23 December	Negotiation of arrangements with CHS
1 December – 15 January	Drawing up of s75 Agreement
w/c 18 January	Signing of s75 Agreement
January-March ‘16	Mobilisation / Implementation of service

3.4. Term of arrangements

3.4.1. The proposed term for the Section 75 agreement is an initial term of three years, with a further extension period of up to two years. This term enables the provider to invest in the necessary changes to infrastructure and staffing to deliver the new service model, while also allowing flexibility for the Council.

3.5. Sourcing/delivery options considered

The project team have considered a number of other routes for arranging delivery of sexual health services, including several options for formal procurement of the services as detailed below.

3.5.1. Open or restricted tender:

An open (one stage) or restricted (two stage) tender process is being followed by many boroughs for sexual health services. The provider market is relatively underdeveloped with NHS Trusts providing the bulk of provision. An open or restricted tender process has been discounted because it is believed that the effectiveness of the service depends on the Council’s public health partners working collaboratively across all areas of sexual health, including in conjunction with GPs and Pharmacies. It is not considered that an open tender process would improve value for money or quality over and above the proposed approach while the negotiation process for the s75 arrangements will allow commissioners to enter into detailed dialogue with CHS to fine-tune requirements and funding arrangements and ensure further integration of services.

3.5.2. s.75 Agreement (preferred option):

Powers provided to local authorities and NHS bodies (such as CHS) under s75 NHS Act 2006 and associated Regulations provide that a local authority and an NHS body can each delegate certain prescribed functions to the other to exercise on their behalf, provided that the resultant partnership arrangements "are likely to lead to an improvement in the way in which those functions are exercised”. The health-related functions that the Council could delegate to an NHS body include public health services and contraception.

In the context of the re-commissioning of Croydon sexual health services, the Council could consider approaching CHS as a s75 partner for the provision of sexual health services and, by entering into a s75 agreement with CHS, cement its partnership with them in the provision of high-quality sexual health services.

3.5.3. In-house provision is not considered appropriate given the highly clinical and specialist nature of the majority of the service provision.

3.6. Social value

3.6.1. The agreement will include an expectation that Croydon Health Services provides sexual health training to local healthcare staff as well as wider front-line staff as currently delivered for those working with young people. This upskilling of the wider workforce should deliver improved outcomes for more vulnerable people who may not otherwise access services. This and other social value considerations will be built in to the specification and negotiation stage.

3.6.2. The Council's Social Value Toolkit will be provided to CHS to ensure that a suitable social value offer is incorporated into the s75 agreement.

3.7. Service and outcome monitoring

3.7.1. Monitoring of the service and the s75 agreement will be undertaken by Public Health Commissioning within the Integrated Commissioning Unit (ICU) in the main, with strategic management of the agreement undertaken by the Strategy, Communities and Commissioning (SCC) team.

3.7.2. CHS will be expected to report on all outcomes, key performance and quality indicators and information requirements as laid out in the s75 agreement. These will include data relating to the chlamydia screening programme, whether this activity is delivered directly or sub-contracted. It will also include information on activity levels for various interventions in various settings, ease of access/waiting times, HIV testing offers and uptake, partner notification rates for sexually transmitted infections, service user feedback and service user demographics.

3.7.3. This information will be used to monitor delivery of the commissioning principles detailed in 3.2.4, including the targeting of service provision to those communities with the greatest sexual health needs.

3.8. Finalisation of arrangements

3.8.1. Some of the detail of these arrangements, including those for the integration of the chlamydia screening programme, is still to be negotiated with Croydon Health Services. In addition, as detailed in section 4 of this report, further revisions to the service model may be required in response to the results of focus groups scheduled for autumn 2015.

3.8.2. In order to allow the flexibility to respond to those negotiations and engagement findings, and to enable further revisions arising from discussions at Cabinet, it is recommended that Cabinet delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Families, Health and Social Care to make subsequent changes to the arrangements proposed in this report. If applicable, the updated report will be published on the Council website no later than 31 December 2015.

4. CONSULTATION/ENGAGEMENT

4.1. A programme of service user and target group engagement is underway that will inform the detail of the proposed integrated sexual health service model.

This is seen as being of key importance in terms of the current and ongoing developments in this area of service.

4.2. The engagement work already undertaken includes a survey and face-to-face work with target groups, as well as collation of all engagement activity recently undertaken by the current service provider. The draft report of the survey findings is available at Appendix A; however, key points include:

- **Access to Services:** This was the most commonly reported barrier to using sexual health services: service opening time was reported by 44% of respondents and the service being too far away/difficult to get to was reported by 27% of respondents. However, not knowing about what the services are, what they provide or where they are were also commonly reported barriers to using services.
- **Settings for Sexual Health Services:** The large majority of respondents reported that they would be comfortable using sexual health services in a clinical/healthcare setting (92%) while 39% were comfortable using sexual health services in a community setting (e.g. children's centre) and 34% were comfortable using sexual health services online.
- **Accessibility:** 64% of respondents reported that being able to access sexual health services on a bus route was important to them.
- **Location:** The most popular location for sexual health services in the borough was central Croydon (64% reported that services should be located in the central area).

4.3. The need for engagement with patients and the public in case of any changes to service provision is acknowledged as an essential requirement for this work and commissioners and CHS have taken learning from previous changes to clinic provision in the Borough. The lead Consultant in Public Health met with members of independent patient participation groups (PPGs) in Croydon to discuss opportunities for the Council to engage with the PPGs in the future that will be considered further. Since Croydon Council is now embedded as the commissioner of these services, service developments have been discussed frequently between the commissioner and CHS.

4.4. More detailed focus groups will be undertaken in the autumn to provide additional information on how we can better meet the needs of specific target community groups. These will form part of a longer-term engagement plan around sexual health to be developed by November 2015.

4.5. The incumbent service provider undertakes continual assessment of service user feedback through a 'friends and family' test that asks whether service users would recommend the service to friends and family should they need it. In 2014/15, 97% of respondents said they were 'likely' or 'extremely likely' to recommend the service, while only 1% said they were 'unlikely' or 'extremely unlikely' to recommend it. In addition, the service ran a more comprehensive snapshot survey of patient satisfaction in 2008 which showed generally high levels of satisfaction with service. Where areas for improvement have been identified, these have largely been addressed where possible and appropriate.

4.6. Croydon jointly hosted a market warming event with five other South West London boroughs in January 2015. As well as informing potential providers

about the boroughs' commissioning intentions at that time, it was also a useful opportunity to learn from a wide range of providers about what they would like to see in a service or tendered contract, such as longer contract terms, mixture of block and tariff/outcomes-based payment models, and what some of the barriers to delivering integrated services can be for providers. The findings from this event have informed some of the proposed arrangements for the Croydon integrated sexual health service.

4.7. Sexual health commissioners from all the South West London boroughs meet regularly to share developments and plans and look for opportunities to collaborate. These meetings have informed some of the options presented.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

1 Revenue and Capital consequences of report recommendations

Previous Year		Current year	Medium Term Financial Strategy – 3 year forecast		
2014/15		2015/16	2016/17	2017/18	2018/19
£'000		*£'000*	*£'000*	*£'000*	*£'000*
	Revenue Budget available				
3,818	Expenditure	3,639	3,459	3,279	3,279
	Income				
	Effect of decision from report				
3,818	Expenditure	3,639	3,459	3,279	3,279
	Income				
0	**Remaining budget**	0	0	0	0
	Saving Against 2014/15 budget	4.69%	9.40%	14.12%	14.12%

Agreed expenditure for the services in scope of this report are included for 2014/15 and 2015/16 in the table above to demonstrate the savings already made compared to 2014/15.

2 The effect of the decision

The proposed integrated sexual health services will result in a more effective service at a cost 14% lower over three years compared to the 2014/15 baseline. The value of the future agreement for these services is not anticipated to exceed £3.279m per annum by 2017/18.

3 Risks

Although the new service model should mitigate this risk, potential pressures may still exist as a result of increased need, improved accessibility of the service and/or population changes. Ongoing reviews of activity and funding would be necessary to ensure that changes in activity that can not be addressed through the revised service model, such as

population growth, are considered fairly.

The revised service model may result in reduced levels of some activity and there are opportunities for cost saving as patients will, where appropriate, be able to have all their sexual health and contraception needs met in one visit rather than having to access two separate services.

As the proposed service model involves the movement of some non-complex activity to GPs and pharmacies, there are potential cost pressures for the Council in this area.

4 Options

Potential arrangements for sharing the risks detailed above could be negotiated with CHS, such as that above a certain activity threshold Croydon Council becomes liable for excess costs, or below a certain threshold Croydon Council receives a refund of a proportion of the budget. These details will be considered at the negotiation phase.

5 Future savings/efficiencies

The redesigned model of integrated sexual health services will deliver savings of 15% by 2017/18 compared to the 2014/15 combined budgets for genitourinary medicine (GUM), Contraception and Sexual Health (CaSH) and young people's sexual health outreach services (excluding the value of the chlamydia screening programme).

Negotiations regarding the chlamydia screening programme element of the service are not yet concluded and opportunities for efficiencies resulting from the integration of this service are still being considered. The values stated are therefore maxima and may be subject to further reductions.

6 Approved by: Lisa Taylor, Head of Finance and Deputy S151 Officer

6. COMMENTS OF THE BOROUGH SOLICITOR AND MONITORING OFFICER

6.1. The Council Solicitor comments that the terms and conditions of the partnership and the way in which the delegation of functions will work would be captured in the Section 75 agreement. While there should be certain key elements, such as around how pooled funding is arranged, beyond that, the content of a s75 agreement is for the agreement of the parties. Consequently it could include detailed provisions around what services CHS would provide pursuant to the delegated functions, the terms on which those services are to be provided, agreed approaches to the procurement of sub-contractors, required outcomes, performance management and reporting, funding etc.

6.2 Approved by: Gabriel Macgregor, Head of Corporate Law on behalf of the Council Solicitor & Monitoring Officer

7. HUMAN RESOURCES IMPACT

7.1. A section 75 agreement should have appropriate employment protections, risk mitigations and policy signposting. There are no other immediate human resources considerations that arise from the recommended approach for Croydon Council employees.

7.2 Approved by: Michael Pichamuthu on behalf of Heather Daley, Director of Human Resources

8. EQUALITIES IMPACT

8.1. A full Equalities Analysis was undertaken in January 2015 to assess the impact the changes to the service would have on specific groups that share a "protected characteristic" such as young people, particularly those being looked after by the local authority, those leaving care, and those not in education, employment or training; young Black Caribbean, Black African and other Black population groups; men who have sex with men; those who misuse drugs or alcohol; and sex workers. The Joint Strategic Needs Assessment (JSNA), completed in 2010/11, identified that these groups experience worse sexual health outcomes.

8.2. This equality analysis remains of relevance for this proposal and will be updated upon completion of the public engagement work in November 2015 to ensure the final model takes full consideration of its findings and recommendations. The analysis identified that there is greater sexual health need in certain protected groups, for example: HIV prevalence is higher among Black Africans and men who have sex with men (MSM); chlamydia prevalence is higher among young people.

8.3. The equality analysis identified that the proposed integrated sexual health commissioning arrangements are likely to have a positive impact on equality groups that share a "protected characteristic", such as: BME groups; LGBT individuals and those who have undergone gender reassignment; younger people; men; women; those with disabilities; and some religious groups. The positive benefits identified include: improved access to full range of contraceptive services, STI testing and treatment; reduction in unplanned pregnancy including teenage pregnancy; improved access to pregnancy testing and referral to maternity or abortion services; and reduction in STI prevalence, HIV incidence and HIV late diagnosis.

8.4. The equality analysis also identified that the proposal could potentially have an adverse impact on some of the equality groups mentioned if the increase in local, community-based services results in increased concerns over anonymity. However, this risk will be mitigated by maintaining a choice of settings, locations and times to access sexual health services. Lack of awareness of service locations following changes could also have an adverse outcome for some equality groups. However, this will be mitigated by the implementation of a comprehensive communication plan to raise awareness among potential service users.

8.5. There is limited research and data on the potential impact of the proposed changes on people with disabilities so the potential negative impact on this

group is not known, although it is considered likely that the provision of integrated, community-focused services should improve accessibility for those with complex needs or those who may be unable to travel to central service locations. The accessibility of the community-focused service for these specific equality groups will be evaluated once the service is established and mitigating actions will be determined if needed.

8.6. Engagement with target groups and potential service users, including groups that share a "protected characteristic", will be undertaken as part of the service design process. This will inform the changes to service delivery to ensure that potential adverse or negative consequences are minimised or eliminated and that positive impacts are maximised. The Equality Analysis will also be updated following this work, by the end of November 2015.

8.7. The service specification will include a requirement to identify and provide services that meet any specific needs of protected groups as identified in the analysis and to share data and actively participate in the evaluation of the service so that access and outcomes among protected groups can be monitored, including for people with disabilities as detailed in section 8.5 of this report. It will also detail the requirement to undertake engagement work with target groups, the wider community and NHS services and organisations working with these populations. This will help to minimise barriers, improve engagement for people with more complex needs and actively tackle health inequalities.

8.8. The delivery of the Integrated Sexual Health Service Commissioning Arrangements will enable the Council to ensure that it delivers the following objectives that are set out in the Council's Equality and Inclusion Policy:

- Make Croydon a place of opportunity and fairness by tackling inequality, disadvantage and exclusion.
- Foster good community relations and cohesion by getting to know our diverse communities and understand their needs

The Council will deliver these objectives by work with statutory and community partners to address health inequalities within the borough through targeted interventions that help people to be resilient and able to maximise their life chances.

9. ENVIRONMENTAL IMPACT

9.1. The environmental impact of the proposed agreement award is limited; however, the intention to provide more community-focused services is likely to have a positive environmental impact as it will contribute towards a reduction in car, motorcycle and taxi journeys among service users.

10. CRIME AND DISORDER REDUCTION IMPACT

10.1. Sexual health service staff are in a strong position to identify victims of domestic and sexual violence and child sexual exploitation due to the increased

risk of sexual ill health among victims and the opportunity to undertake comprehensive assessments with service users. The integration of training for front line staff for appropriate detection of these crimes and signposting or referral of possible victims will help support crime detection rates and have a positive impact on crime and disorder.

11. REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

11.1. The proposed approach is recommended to ensure continued provision of mandatory sexual health services in Croydon and ensure the Council fulfils its obligations under The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

11.2. The proposed s75 approach is considered to lead to an improvement in the way in which these functions are carried out and will deliver the redesigned integrated sexual health services in Croydon according to the principles detailed in section 3.2.4. Croydon Health Services have already started to demonstrate their ability to deliver the service redesign and take into consideration factors such as whole-system working. This approach will also assist in full implementation of the new model more quickly.

12. OPTIONS CONSIDERED AND REJECTED

A number of other options were considered and rejected in the development of this approach:

12.1. Going out to tender for the redesigned service:
This option has been considered in detail, as most local authorities have either recently tendered their sexual health services or are planning to tender all or part of their provision over the next year or two. Although there are potential benefits to this approach for Croydon, such as formal testing of the market, there are also considerable risks. These include potential fragmentation of the existing system between contraception/sexual health services and HIV treatment, abortion services and gynaecology services. Using a s75 approach to work in partnership with Croydon Health Services is considered more likely to lead to an improvement in the way the sexual health services functions are exercised, given the considerable progress that has been made in recent months and the robust pathways that already exist between services.

12.2. Recommissioning the service in its current form:
This option was briefly considered; however, good progress has been made with the service redesign that should deliver improved focus on communities with the greatest sexual health needs and an improved, integrated service for patients at a lower cost. This option was therefore rejected.

CONTACT OFFICER:
Ellen Schwartz, Consultant in Public Health
Tel: Extension 61644

Lisa Burn, Senior Joint Commissioner (Public Health)
Tel: Extension 63093

BACKGROUND PAPERS – LOCAL GOVERNMENT ACT 1972

Equality Analysis for Sexual Health service development 2015/16

Appendix A: Draft report on sexual health services survey 2015

DRAFT

Report on the 2015 sexual health services survey

Summary

Croydon Council and Croydon Health Services are working together to improve the sexual and reproductive health services available to people in Croydon. These services provide contraception, testing and treatment for sexually transmitted infections (STIs) and information and advice about sexual health.

To inform how and where services are available, we ran a survey to gather views from local people. 244 people completed the survey between 1 May and 12 June.

Respondents felt that access to services was very important, with opening times (44%) and service locations (27%) being the most commonly reported barriers to accessing services. Respondents were most likely to be comfortable accessing sexual health services in a clinical/healthcare setting (92%). Locally-located services (within 30 minutes travel time) and services on a good bus route were important and central Croydon was the most popular location reported for services. Suggestions made for services included longer opening hours, dedicated clinic times for different groups of people and different types/locations of services.

Full results are detailed below.

Background

Sexual health services are currently provided by GP practices, pharmacies and at two specialist sites: contraception at the Edridge Road health centre and STI testing and treatment at a Croydon University Hospital building on London Road in Thornton Heath. Although there is some out of hours availability, the majority of service provision is delivered Monday to Friday in normal office hours. There are some clinics within the specialist services that are specifically for young people; all others are open to everyone.

To inform an updated plan for how and where sexual health services should be delivered, a period of public and service user engagement was planned. The sexual health services survey was therefore opened for responses initially between 1 and 20 May 2015 and then extended until 12 June.

The survey was predominantly run online. In addition, paper copies of surveys were distributed on request throughout the survey period for those who did not have internet access or preferred to complete the survey in hard copy. Paper copies were also distributed over one day by public health staff in Access Croydon, Croydon Library and the Healthy Living Hub. 63% of responses were received online; 37% were via paper surveys.

The survey was promoted via the Council website and flyers detailing the survey web address were distributed via the sexual health services, GP practices and pharmacies. The same publicity was also displayed on plasma screens in sexual health services and Croydon Council. A link to the survey was

sent out by email with background information to the public health team and other Croydon Council staff, Croydon Clinical Commissioning Group, and local services. In addition, it was sent to 19 other community/voluntary organisations and networks for promotion with their service users and/or members, including HealthWatch Croydon, with a particular effort to get the survey to those groups most at risk of poor sexual health outcomes. The survey was also promoted via the Council's facebook page and twitter feed. Several notices about the survey were also published on the Council's Streetlife page.

Where the report below details a percentage of respondents, this is the number of individuals as a percentage of the total number of responses to the survey as a whole, including those who did not respond to a particular question. Not all survey respondents answered all questions.

About the respondents

A total of 244 individuals completed the survey. 66% were over the age of 25, 65% were female and 44% belonged of black and minority ethnic (BAME) groups. Four female respondents reported that their gender now was not the same as the gender they were assigned at birth.

The majority of the group were heterosexual and 4% described themselves as men who have sex with men (MSM) or gay men. Nine individuals (7 females and 2 males) described themselves as bisexual. One respondent described herself as a woman who has sex with women/gay woman. There was a group of 27 individuals who reported that they had a disability or condition which limited their daily activity in some way. One fifth (21%) of respondents who provided their postcode lived in either Fairfield or Addiscombe.

The sample responding to the survey cannot necessarily be taken as being representative of the population of Croydon due to the methods used to promote it and the number of responses. As such, these results should be interpreted as the views of the survey respondents. Additional engagement work will seek to engage target groups who may not have participated.

Previous use of sexual health services

148 individuals who completed the survey (61%) reported that they had attended sexual health services in the last two years. The sexual health service at Croydon University Hospital (CUH) and Contraception and Sexual Health (CASH) service at Edridge Road were the most commonly used sexual health services (31% and 41% of respondents who had used sexual health services in the last two years, respectively, had attended these services). 22% of those who had used sexual health services in the last 2 years had done so in GP surgeries. However, these findings may have been influenced by the survey promotion methods and by respondents' interpretations of sexual health service provision.

As shown in the graph below, the group of respondents who had used sexual health services in the last 2 years contained a higher proportion of young people (under 25), a higher proportion of women and a higher proportion of MSM than the group of respondents who had not attended sexual health services in the last 2 years. The proportion of BAME respondents who had and had not attended sexual health services in the last 2 years was similar.

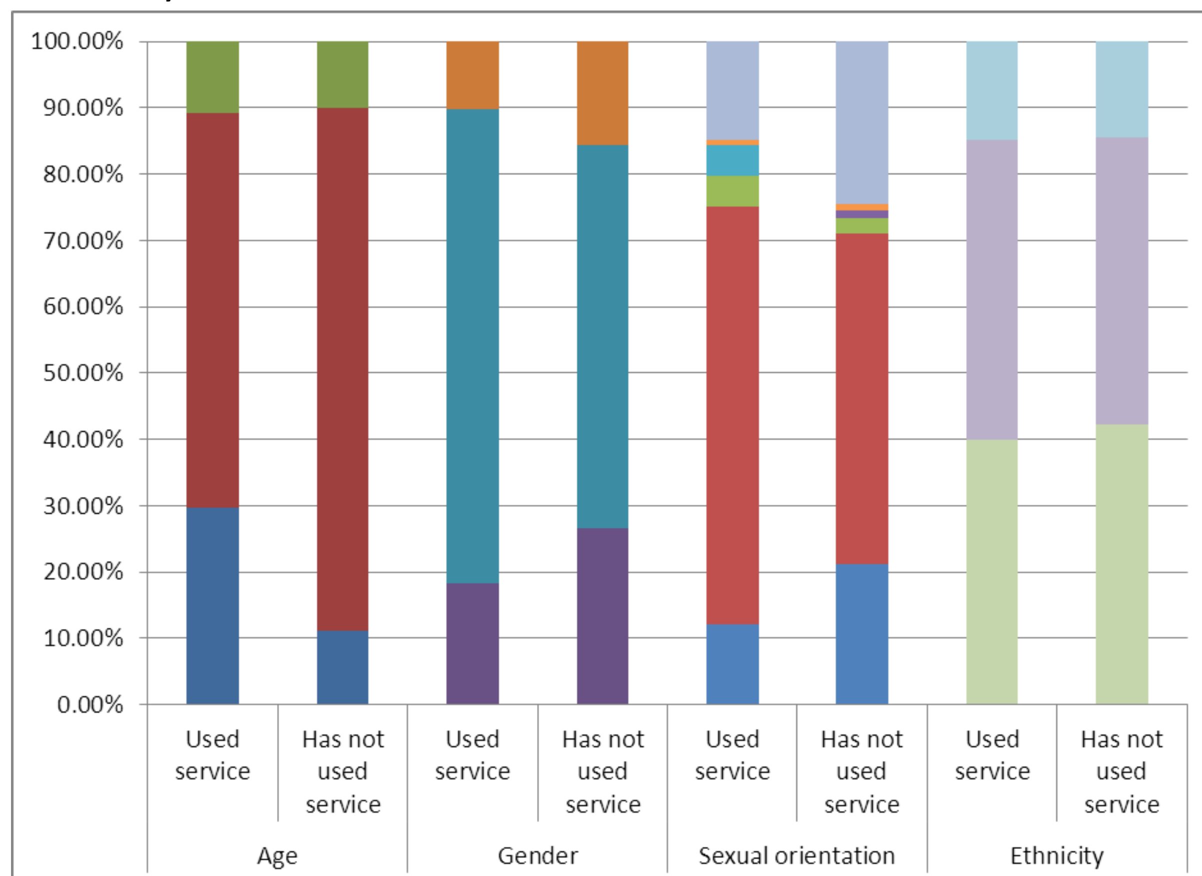
The most commonly reported reasons for using sexual health services in the last two years were needing a check- up (37%) and wanting advice on contraception (47%). However, this finding should

also be viewed with caution as these results may also have been influenced by the survey promotion methods.

More than three quarters (76%) of respondents who had attended sexual health services in the last 2 years rated the services they had attended as very good or good.

Comments provided about the sexual health services which had been used generally focussed on a good service from the staff but difficulties in access to services.

Graph showing the characteristics of people who have and have not used sexual health services in the last two years



Key:

Age	Gender	Sexual orientation	Ethnicity
Unknown	Unknown	Unknown	Unknown
Aged >24	Female	Other	BAME
Aged <24	Male	Male bisexual	White
		Female bisexual	
		Woman who has sex with women	
		Male who has sex with man	
		Female heterosexual	
		Male hetersexual	

Barriers to using sexual health services

Access to services is the most commonly reported barrier to using sexual health services: service opening time reported by 44% of respondents and the service being too far away/ difficult to get to

reported by 27% of respondents. However, not knowing about what the services are, what they provide or where they are were also commonly reported barriers to using services.

Preferences for sexual health services

The large majority of respondents reported that they would be comfortable using sexual health services in a clinical/healthcare setting (92%) while 39% were comfortable using sexual health services in a community setting and 34% were comfortable using a sexual health service online.

Most respondents reported that they would use a sexual health service near to where they lived (85%) and/or where they worked (62%). Only 22% of respondents reported that they would travel for more than 30 minutes for a routine appointment. For urgent appointments respondents were more willing to travel for longer periods, with 27% reporting that they would travel more than 30 minutes for services.

64% of respondents reported that being able to access sexual health service on a bus route was important to them. The most popular location for sexual health service in the borough was central Croydon (64% reported that services should be located in the central area).

Further comments about sexual health services

Three main themes are present in the comments section. The first is about appropriate targeting of services and the second is about opening hours and the third is about locations of services.

(i) Individuals highlight the benefits of services being targeted for specific groups of people and having dedicated clinics that particular groups of individuals can attend.

> "*Maybe having different types of clinics for different groups of people - older people may not wish to attend a clinic that is full of younger people and vice versa, or having a female only clinic and male only clinics*."
>
> "*Should have an evening clinic for gay/lesbian people*"
>
> *"A gay-specific service would be ideal. The gay community has unique needs when it comes to sexual health, and often local council clinics can seem quite out of tune with these needs. I visit Dean Street in SoHo as they offer a judgement-free yet supportive and positive experience for gay men and women. I'd be happy with even one night a week where our particular needs are addressed and understood."*
>
> *"Need to cater for women who are 40 years and over."*
>
> *"More days when it's for young people only Not always open to just the general public"*

(ii) Extending opening hours to evenings or early mornings was seen as beneficial to improve access to services.

"As more and more people are getting into work, it would be helpful to have plenty of options for out-of-hours appointments - I know that I struggle to make it for walk-in clinics whilst working full time!"

"I think the main problem is opening hours. Some people in Croydon actually work so evening appointments up to 9pm should be available"

"Just three things: opening hours, opening hours and opening hours - could be extended perhaps....."

(iii) A number of suggestions about additional type or locations of services were made.

"There is a lack of services available to those in the southern areas of Croydon. The only option is to use your GP, but not all GPs offer contraceptive services, and appointment times are restricted, esp if you required emergency assistance."

"review opening hours regularly and maybe even look at going Mobile with a bus/similar to the breast screening trucks - non branded"

"Few places in upper Norwood area More providers STI services would help"

"Provide a home service option."

Next steps

Croydon Council is planning to undertake a series of focus groups with communities that have worse sexual health outcomes (e.g. higher rates of HIV or abortions) or other needs that might need taking into account. The focus groups will help us to understand the issues these communities face so we can meet these needs better.

The survey results and findings from the focus groups will be used to inform how the integrated sexual health services are run in the future.

A full report on the findings of the survey and focus groups will be published by the end of 2015. This will also include information on how the services have changed as a result of this feedback.