Report for: Cabinet December 15th 2015

Item number: **20**

Title: **London Sexual Health Transformation Programme - Commissioning and Procurement Strategy**

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Ward(s) affected: All

Report for Key/
Non Key Decision: Key decision

1. **Describe the issue under consideration**

1.1. There is a unified call across London councils for action to stem the rise in sexually transmitted infections (STI). London has higher rates of STI than the rest of England and in 2014 levels rose again; this included a 40% increase in syphilis and 23% in gonorrhoea diagnoses. In Haringey and the rest of London there is an increasing demand for sexual health services paid for from the public health grant. It is projected that without action use of sexual health clinics will escalate, severely challenging public health budgets. This situation underpins the need for a major transformation of services and collaborative responses between London councils.

1.2. This paper makes recommendations that will set in motion the re commissioning of a modernised network of sexual health services able to meet London's challenging sexual health issues. Because Londoners tend to access services across the capital any impact can only be made if London councils work together. This is being achieved through the London Sexual Health Transformation Programme (LSHTP), 28 Local Authorities (LA) sharing a commissioning strategy and mobilising together to deliver new contracts across London by April 2017.

2. Cabinet Member introduction

2.1. The poor sexual health of Haringey residents is of concern and clearly linked to delivery of priority 2 of the corporate plan. A new service vision is required and I therefore welcome this opportunity to totally reshape service delivery and build an ongoing commissioning structure able to meet the evolving sexual health requirements of our residents. The old NHS clinic model has served residents well, but with rapidly developing health technologies there are alternative services available to often long waiting times in NHS clinics. Home/self-sampling will suit many of our residents and I have already witnessed the innovative way we are using the skills and great locational

settings of our Health Living Pharmacies to offer STI testing and some treatments[1].

2.2. With 60% of Haringey attendances for sexual health services being outside of the borough, it is clear that it is in the Councils best interest to be part of this London wide unified strategy for the procurement of Genito-Urinary Medicine (GUM) and Contraception and Sexual Health services (CaSH). That 28 LA are working in partnership demonstrates the strength of senior leadership within this programme.

2.3. There are firm grounds for agreement to procure as a north central sub region as this echo's residents existing access points. The redesign process will have a strong Haringey voice and will create innovative and services whilst also delivering financial efficiencies.

2.4. To be part of this London wide collaboration is essential in order to achieve the transformation of the service model to deliver measurably improved and cost effective public health outcomes, meet the increasing demand and deliver better value for Haringey residents.

3. Recommendations

3.1. Approve the Council's participation in a London wide procurement for a web-based system to include a 'front-end' portal, joined up partner notification and home/self-sampling, to be led by one council on behalf of the councils in the LSHTP.

3.2. Approve the Council's participation in a sub-regional procurement strategy for re-procurement of a contract for GUM and CaSH services. Participating councils in the sub region include Barnet, Camden, City of London, Haringey, Hackney, Enfield and Islington.

3.3. Note that the Leader has agreed to take responsibility for approving the awards of the contract for the web-based system to be procured in accordance with paragraph 3.1 and of the contract for GUM and CaSH services to be procured in accordance with paragraph 3.2.

3.4. Note that the leader has agreed to take responsibility for approving the new collaborative commissioning model for the Council to participate in London-wide cross charging once this has been developed in accordance with the proposals in paragraphs 4.11 of this report.

3.5. Note the progress made in developing options for the future commissioning and procurement of GUM and CaSH services and the named inclusion of the Council in the Prior Indicative Notice (PIN) and Official Journal of European Union Notice (OJEU) for procurement of these services at the subregional level as part of the strategy referred to in paragraph 3.2.

3.6. Approve an extension of the Council's current contract with Whittington Health NHS Trust for provision of an integrated GUM and CaSH service to residents

[1] http://www.haringey.gov.uk/social-care-and-health/health/public-health/healthy-living-pharmacy

of the borough for a further 18 months from 1st April 2016 until 30th September 2017 subject to an option for the Council to terminate the contract after 31st March 2017 on 1 month's notice. The contract value for the period of extension will be pro rated based on a full year rate of £2,582,000.

4. Reasons for decision

4.1. Approval is being sought on the recommendations outlined in 3.1-3.5 across all 28 LAs participating in the LSHTP[2]. They have been agreed by both the LSHTP board chaired by Mike Cooke, Chief Executive of Camden Council and the London Association of Directors of Public Health.

4.2. Haringey residents have high rates of sexually transmitted infections and although now reducing have had high rates of teenage pregnancy. This suggests that, although costly, sexual health services for Haringey residents need to be more effective. The Council wants to support residents to make healthy choices and to have better sexual and reproductive health.

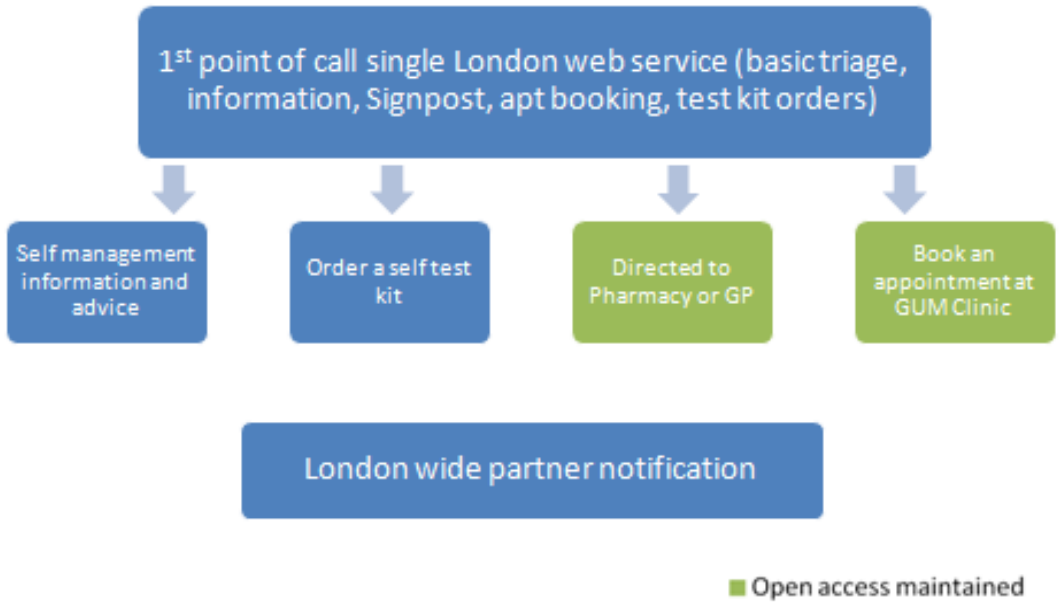
4.3. The LSHTP recommendations are underpinned by a business case, which demonstrates the imperative to transform the commissioning of sexual health services in London, rather than just gradual transformation or making no change. The business case is based on a detailed needs assessment, a survey completed by 24 provider NHS Hospital Trusts, provider interviews, 8 workshops, and a survey of 1,377 service users. In addition work was completed in three sub groups of the LSHTP board exploring clinical requirements, financial benefits/models and procurement strategies. Haringey Council officers are participating at every level of the LSHTP from sub groups to the programme board.

4.4. Paragraphs 4.5 to 4.11 below identify the reasons for the recommendations relating to *procuring a web based front* end for London; participating in a *north central London sub regional procurement; delegating authority for progressing the commissioning of relevant services and finally* continuing to *cross charge* for activity within the LSHTP 28 boroughs;

4.5. **Web based front end** Commissioning a web based innovation will allow Londoners to explore on line, different sexual health service options and if the requirement is for a clinic, make an online appointment, see Figure 1. The results of a customer survey suggest, given better options, 15% of clinic users will opt to switch to a non clinc based service i.e. order a home testing kit or find a local pharmacy. The advantages of procuring this service on a London wide basis includes being able to offer extensive choice of London clinics, cost advantage from scale and will enable a high profile marketing strategy to persuade customers to switch from telephone to on line booking.

Figure 1 – web based system as a process

[2] At present the 28 London boroughs include; Barnet, Brent, Camden, City of London, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Islington, Kensington & Chelsea, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Tower Hamlets, Waltham Forest, Wandsworth, Westminster, Kingston, Richmond, Hounslow, Havering, Bexley, Bromley (also potentially Sutton and Croydon making 30)



4.6. **North central London sub regional procurement of GUM and CaSH services** The London LAs are proposing a sub regional model of commissioning which networks across the capital. The rationale for this is outlined below and highlights a balance between the ability to procure local services to meet residents' needs with a higher degree of cost and quality control obtained through larger contracts, thus gaining economies of scale.

4.7. ***Benefits*** - The sub region model creates the opportunity to co-commission local services with partner LAs and to be able to influence services in other sub regions where Haringey residents go for services. The aim is to have consistency across London.

4.8. There are significant benefits for providers in operating across a larger sub regional network in terms of best use of estates, economies of scale for service overheads and the offer of a work environment that would be attractive to high quality clinical staff.

4.9. LAs too would achieve economies of scale on back office and transactional costs.

4.10. **Delegating authority** In terms of delegated authority it is recognised that it would not be timely for all 28 LAs across the sub regions to return to their Cabinets for award of contracts within the sub regions. The schedule for contracts starting in April 2017, when the existing agreements expire, is already ambitious and must be kept to if providers are to be given sufficient time to execute the new contracts.

4.11. **Cross charging** - Residents will continue to be free to access GUM services across London. The aim is that Haringey will be invoiced by each provider across London for these services at the same price agreed for the host sub region, i.e. there will be a single price negotiated for the whole of London by

each sub region based on a standard service design. With external legal support, Commissioners will identify and develop a new collaborative commissioning model to facilitate cross charging in this way across London that minimises bureaucracy, as further explained in this report and particularly in paragraphs 6.22 to 6.25.

5. Alternative options considered

5.1. Officers across the 28 boroughs have reviewed 3 main options for commissioning the sexual health services.

- Option 1: Do nothing. Current system remains unchanged.

- Option 2 (described in section 4): Develop a network system based on 4 sub regions.

- Option 3: LAs to focus on the development of a local service model that includes GUM reducing dependence on central London services.

5.2. **Option 1: The current system remains unchanged -** Under this option councils would continue with the current arrangements and undertake any redesign and procurement activity as locally determined. The main advantage of this model is that it does not create any change in provision for residents and the additional commissioning time entailed by Option 2.

5.3. The key disadvantage of this option is that it will not improve access for residents who are now experiencing long waiting times at GUM clinics and inflexibility around opening times. For commissioners there would be no shift in the challenging position of negotiating price and quality annually with multiple NHS Trusts. These Trusts are well aware that they hold a powerful negotiating position with LAs outside of their host area and often hold a non negotiation position.

5.4. The current situation is financially unsustainable. Growth in activity and costs in GUM provision could mean councils having to make savings to other key public health services to fund statutory open access services.

5.5. **Option 3: LAs to focus on development of a local service model reducing dependence on central London services -** In this model LAs would continue to agree GUM services for their own area. The individual LAs could work together via a 28 borough wide sexual health cross charging network arrangement to ensure there is a forum where common issues can be addressed. Benefits include enhanced local control and potentially greater scope to reshape local service provision away from central London and less complex collaborative arrangements than in Option 2. Where this option falls short is because of the movement of residents across London and the risk of LAs acting ‘out of sync’ with each other on price or allowing their local GUM providers to introduce additional capacity, thus pulling in more business into

that high price clinic. In addition this option will reduce the scope for individual commissioners to drive the change and efficiencies offered within option 2.

5.6. **Risks** – A full risk assessment exists at both LSHTP board and within the sub region. Key issues are highlighted below:

5.7. The key risks to achievement of timescales are linked to the complexity of partnership working and scale of change required across London under the recommendation. Some of this is mitigated by having LA Cabinets agree to delegate authority.

5.8. The new model will require 'channel shift' for some customers to a greater on-line offer, this may be challenging particularly for those who are not used to on line booking. There will be a proactive communication strategy to support customers with this change.

5.9. The LSHTP does aim to reduce capacity in GUM clinics and this is likely to lead to service changes as people are directed to community or enhanced GUM clinics.

5.10. The savings forecasted are dependent on some new form of tariff and this must stretch beyond north central London sub region.

6. Background information

6.1 Haringey has high levels of sexual health need.

6.1.2 The latest data relates to 2013. Haringey is ranked 11 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new STIs. 4152 new STIs were diagnosed in residents of Haringey, a rate of 1603.6 per 100,000 residents (compared to 810.9 per 100,000 in England).

6.1.3 35% of STI diagnoses in Haringey were in young people aged 15-24 years (compared to 55% in England). In Haringey the rate of Chlamydia diagnoses per 100,000 young people aged 15-24 years was 2175 (2014).

6.1.4 The diagnosed HIV prevalence in Haringey is 6.88 per 1,000 population aged 15-59 years compared to London at 5.69 per 1,000 population, and England at 2.14 per 1,000 populations.

6.1.4 In Haringey between 2011 and 2013, 48% of HIV diagnoses were made at a late stage of infection compared to 40.5% in London and 45% in England.

6.1.5 Haringey has a number of high risk groups one of which is sex workers, who are often hard to reach with services.

6.1.6 In parallel to the high level of STIs, the rates of teenage conceptions also remains high (although the trend is falling), with Haringey ranked 4th across

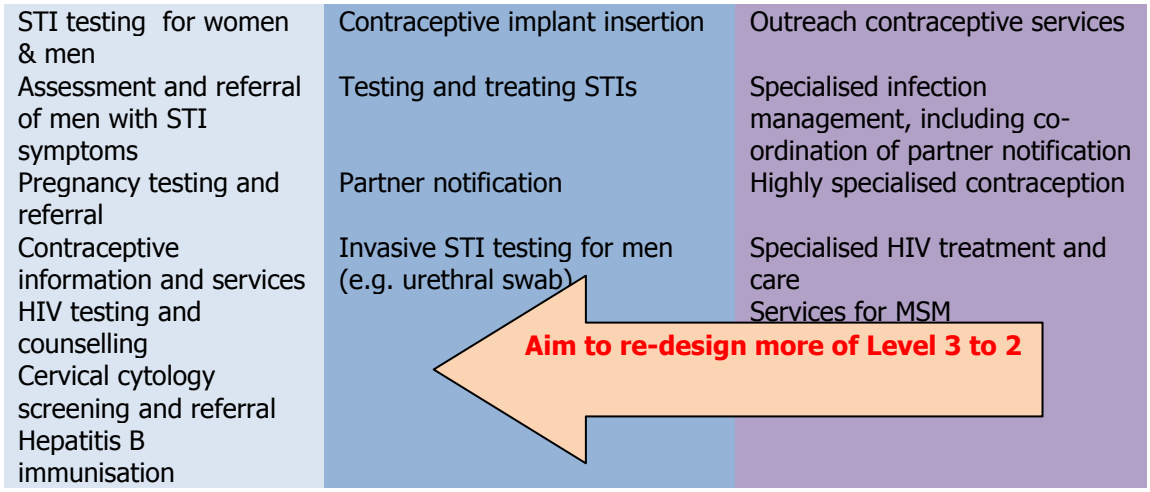
London in 2013, with a rate of 20.9 conceptions per 1000 women under 18 years of age compared to 21.8 per 1000 in London and 24.3 per 1000 in England and Wales. In 2014, over 29% of all abortions, (all ages), were classified as repeat abortions in Haringey – compared to 32.3% in London and 27% in England.

6.2 **Haringey residents' current use of GUM -** Because GUM service is statutory open access, residents can choose to visit sexual health clinics in any part of the country and currently they do this for any sexual health condition irrespective of how serious it is. The situation in Haringey is that the Council commissions a local GUM service provided by Whittington Health NHS Trust based at St Ann's Hospital. However 60% of Haringey resident attendances are outside of Haringey, primarily in Camden, Islington and Westminster. This pattern of resident movement is mirrored across many LAs in London.

6.3 **Haringey's sexual health 'step change' programme -** Over the last two years the Council's 'step change' programme has reviewed the local offer for sexual health testing and treatment. The programme has used new testing technologies and existing skilled community based professionals to create a different approach to a GUM clinic model. Since April 2015 32 pharmacies and a voluntary sector provider have been providing STI testing and non complex treatments 7 days a week, daytime and evening. Emergency Hormonal Contraception (EHC) is now available to all women via participating pharmacists and nurse prescribers. Home HIV self-sampling/self-testing kits have been available from November 2015. GPs in Haringey already provide HIV testing and contraception services. The LSHTP estimates that 15% to 30% of activity could be redirected out of GUM level 3 services to lower cost level 2 service options in a staged manner; this is illustrated in Figure 2.

Figure 2. Redirection of level 3 services into level 2

Level 1 -voluntary sector/pharmacy/GP	Level 2 Primary care	Level 3 GUM
Sexual history and risk assessment	Intrauterine device insertion	Outreach for STI prevention



6.4 **The business case for change –** LAs were given responsibility for commissioning the majority of sexual health services in April 2013, as part of changes under the Health and Social Care Act 2012. In 2013 the Haringey public health team worked with 4 other boroughs to negotiate with 5 local NHS Trusts to control contract prices. In 2014 the 5 boroughs joined with other boroughs in west London to form a 12 borough collaborative to further control contract prices across more NHS Trusts. In 2015 this collaborative arrangement has expanded to 22 boroughs. The LSHTP has brought together 28 London boroughs to design and deliver a new collaborative commissioning model for open access sexual health services across much of the capital, including GUM and sexual and reproductive health (SRH). The aim is more than controlling price it is to lead the transformation of the service model to deliver measurably improved and cost effective public health outcomes, meet the increasing demand and deliver better value.

6.5 The business case outlines five main reasons why this transformation programme is necessary;

I. The need for sexual health services in London is significantly higher than the England average, and has risen significantly in recent years.

II. There are noticeable variations in access and activity across London boroughs, with high numbers of residents from across London accessing services in central London.

III. Given London's complex pattern of open access services, there are important advantages for London boroughs to transform and commission services together.

IV. We must continue to ensure strong clinical governance, safeguarding and quality assurance arrangements are in place for commissioning open access services.

V. We want to respond to current and future financial challenges, and ensure we are making the best use of resources available.

6.6 The business case has been developed by the 28 LAs over the last 18 months, led by Mike Cooke, Chief Executive of Camden Council and Dr Andrew Howe, Director of Public Health for Barnet and Harrow, with input from service users, providers and national clinical agencies.

6.7 **The LSHTP vision for new services** At this stage the vision has been worked up at a London level and includes the following elements outlined below:

6.8 A web based access platform will provide residents 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.

6.9 All major clinics will offer patients the opportunity to triage and self-sample on site and all services will be required to ensure that routine STI screen results are available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered a fast track appointment, ideally within 24 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.

6.10 The Partner Notification System will provide a joined-up, London-wide database intended to ascertain attendance at clinics of those notified of risk of infection and to support the reduction of STI rates of re-infection and repeat attendances. It will reduce the current time and complexity of follow-up of partners across London's many sexual health services.

6.11 Commissioners from the 28 boroughs are working together to agree a standard service design. Clinical expertise from a range of relevant professional bodies and from Public Health England are supporting this work and a number of issues have been highlighted and solutions developed, see below for the key issues.

6.11.1 Service integration - The transformation programme will support integration of GUM and SRH services wherever it is practical and locally supported. The LSHTP is recommending the use of an integrated tariff, which brings together GUM and SRH services into a single tariff scheme, and would expect to see competition on both price and quality of services.

6.11.2 Integration with HIV services - Patients benefit from this, and we need to align planning with NHS England who is responsible for commissioning HIV treatment services. We are aware that re-commissioning GUM and SRH services may have different implications for smaller clinics, where separation of these services from the provision of HIV services is not straightforward, and

we will work to ensure that there are clear and safe pathways between services for patients as part of the transformation programme.

6.11.3 Management of asymptomatic patients - Alternatives to GUM clinic attendance for people who do not have any symptoms of sexually transmitted infections are acceptable to a lot of patients, and there is room for considerable innovation in providing other forms of access, such as ordering home sampling/testing kits on-line. It will be important to ensure that providing alternatives does not lead to increased demand among people with no apparent risk of STIs, but it also offers the opportunity to reach people in high risk groups who may not be accessing current GUM services.

6.11.4 Changes in behaviour and how to respond - Sexual behaviour is changing and some high risk patients do not access clinic based services. We will be looking to specialist services to create innovative solutions to reach these populations and meet emerging needs.

6.11.5 Training, workforce planning and development - We recognise the concern of some that changes in pathways may impact on medical training. Service specifications will be clear about the need to support and facilitate training.

6.11.6 Delivery of partner notification - Despite the potential challenges of delivering a London wide partner notification service, given the importance of ensuring that partners are followed up and the number of different services in London, we believe the benefits make this a worthwhile exercise.

6.12 **Planning in Sub Regions** - Given the size and complexity of London's sexual health services, and the differing needs of local populations, councils are working together in sub regions to develop and implement local plans, within the overall London transformation model and specification. Haringey is part of the north central London sub region.

6.13. **Finance and the procurement process** – Haringey council will lead on the financial elements of the north central sub regoinal procurement process, offering support around forecasting and overseeing the evaluation.

6.14. **Finance -** Greater efficiencies are a key goal for the sexual health programme locally, and across London. Haringey currently has a contract of £2.682million per annum with Whittington Health NHS Trust for both GUM and contraception/SRH and in addition the council spends £2.9million per annum on GUM clinics in other areas.

6.15. The proposal includes the following;

6.16. **Maintaining the current integrated sexual health (GUM and CaSH) services contract with Whittington Health NHS Trust** - extending it for another year to eighteen months until the new sub regional contract is in place

around April 2017; a further £181,000 saving will be made on this contract in 2016/17.

6.17. **Entering into an NCL sub region** - Haringey is currently spending 45% of it's out of area GUM expenditure within the sub region. This is in clinics in Camden and Islington.

6.18. **A front end portal** which will have a marginal cost as it will be spread across 28 LA. This will create service savings from being self service i.e. staff time on booking and providing service information.

6.19. Having a portal with access to home sampling and referral to community services is expected to divert 15% of GUM users to community services.

6.20. The plan locally is to further develop the primary care offer of GUM and CASH services.

6.21. **The NCL sub region tender** - will be looking for a service covering Haringey, Camden, Islington and Barnet with close links to Enfield, City of London and Hackney contracted services. The tender process will allow for financial modelling of the new service. This is expected to create efficiencies either from the cost reduction of the service redesign or through a pricing tariff.

6.22. **Move to integrated tariff** - The aim is to try to reduce out of area use of GUM and CaSH services, but residents will still access services outside of the NCL sub region. It is therefore imperative that London accepts an integrated tariff within a maximum price for services agreed by all London commissioners. Currently there is a pricing system, a price for a first appointment and then lower price for a follow up appointment. But prices are inconsistent for example within central London one provider charges £164 for a first appointment and another £129. London is piloting an Integrated Tariff, where the price paid is linked to complexity of care. With no change in activity levels, saving estimates from this system would be £300,000 for Haringey.

6.23. **Cross charging** – Councils will continue to have cross charging arrangements, but no resources are transferred between councils as LAs are independently invoiced by the providers.

6.24. **Legal** Given the value of the commissioning involved in the LSHTP, it is proposed to use independent external legal advice to identify and develop a new collaborative commissioning model that will coordinate cross charging arrangements with providers in all the participating sub regions across London based on a standard service design and integrated tariff.

6.25. Local legal teams will remain fully informed of the process.

7. Contribution to strategic outcomes

7.1. Participation in the LSHTP to modernise and redesign sexual health services contributes to Priorities 1 and 2 in Haringey's Corporate Plan. Within priority one, we will expect the service to have a core offer for young people, promoting their health and wellbeing and safeguarding them from harm. For priority two the expectation is that the new model will emphasise prevention and testing by making healthy choices easier to make.

8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

8.1. **Procurement** Officers seek authority to participate in a collaborative procurement with Barnet, Camden, City of London, Hackney, Haringey and Islington for a new integrated sexual health service consisting of both GUM and CaSH services for all boroughs.

8.2. Cabinet support from the individual boroughs has been sought between November 2015 and January 2016. This allows for the formal procurement to commence in February 2016 with the contract(s) awarded by the end of the year to allow for an April 2017 start.

8.3. In the north central London sub region Islington Council will lead on procurement in consultation with the other LA procurement teams. It is intended that the procurement will be undertaken using the *competitive procurement with negotiation p*rocedure under the Public Contract Regulations 2015. This approach will allow the councils to work with interested parties to build the specification. This approach is more flexible and allows for more tailored and innovative specifications and solutions to be developed against an overall service model, key outcomes and performance indicators developed by commissioners.

8.4. It is proposed that a Quality/Price split of 50:50 is used in the assessment of tenders, with the quality assessment being broken down into: service model; clinical governance and assurance, social value and workforce. The involvement of the four boroughs, each with a different view of quality/price split and the fact that major providers are NHS Hospital Trusts suggests it is the most pragmatic and sensible approach.

8.5. The proposed initial contract term of the sexual health service to be procured will be 5 years, commencing 1 April 2017 to 31 March 2022; with an option to extend for up to a maximum of 3 (1+1+1) further years (up to March 2025), subject to performance and funding availability.

8.6. The existing contracts for GUM and CaSH services in Haringey were previously tendered in 2014/15 and are awarded for up to three years (1+1+1). The proposal is to extend the contract beyond the initial year by 1 1/2 years so it will be terminated at latest on 30th September 2017 or after 1st March 2017 on 1 month's notice to coincide with when the new contract starts.

8.7. The Leader has agreed to take responsibility for approving the award of the new contract to ensure a timely contract award to maximise lead in time for the new contract.

8.8. Pan-London Procurement of online services, access to test kits for self-sampling and London-wide partner notification system (The Pan London Procurement Project) will be led by a single LA on behalf of the 28 LAs in the LSHTP. This is a model currently used successfully to procure London wide HIV prevention work.

8.9. The market engagement activities suggest a number of current and potential providers with the scope to deliver services at scale. Online and self-testing/self-sampling services are a rapidly developing market. There are, though, few examples of providers with a track record in providing all three elements, and therefore the service will be commissioned in three lots:

- Triage and Information ("Front of house") and Appointments (Booking system) (dependent on ability to interface with existing clinic systems).
- Self-Testing/ Self-Sampling
- London-wide Partner Notification system

9. Comments of the Chief Finance Officer and financial implications

9.1 Sexual Health services are funded from with the Public Health grant. In common with many London authorities, Haringey spends a relatively large proportion of its grant on these services: £6.366 million (which is just over 30% of the total grant.) This is the 2015/16 budget figure which includes a saving of £603k since 2014/15.

9.2. Due to its demand led nature and the statutory obligations around payment for walk in services anywhere in the country this budget is harder to control in the short term. However the service is planning to make a further million pounds of savings in the medium term financial strategy (MTFS) (£0.339 million in 16/17 and £0.742 million in 17/18.) These are challenging savings that would be difficult to meet within the current contracts and services.

9.3. However this report sets out a new approach to delivering the service that should provide significant benefits including substantial savings. This approach includes close working with other London authorities and a redesign of services which includes wider access to lower cost community based services and more efficient practices within GUM clinics.

9.4. The first benefit to be realised is the adoption of a cross London integrated tariff charging system for sexual health services which is expected to produce savings of around £0.3 million for Haringey. Further savings are then expected as a result of the reprocurement of the sexual health services contracted within the north central London sub region. The current value of these services is in the region of £3.9m. Modelling carried out as part of the preparatory work suggests that savings could be in the region of 10% to 25% (ie £0.4m to £0.97m.)

9.5. A full assessment of the savings achieved by the procurement will be made before the contract award and will contribute to the savings targets in the MTFS. Any shortfall between savings achieved by this procurement and the integrated tariff and the overall savings target of £1m will need to be identified from elsewhere within the sexual health budget.

9.6. Officers from the Council's finance department will be involved in supporting the procurement exercise.

10. Comments of the Assistant Director of Corporate Governance

10.1 The Assistant Director of Corporate Governance has been consulted on this report. The report is seeking approval for a procurement strategy involving moving towards a new model for commissioning sexual health services and is noting progress in moving towards the new model. As part of this the Council's inclusion in the OJEU notices initiating an aspect of the procurement is noted in paragraph 3.5 of the report.

10.2 Paragraphs 3.1 and 3.2 are seeking approval for a procurement strategy that involves the Council undertaking joint procurements with other London boroughs, respectively, of a pan London web-based system and at the sub-regional level of GUM and CaSH services. Each procurement will be led by another Council. Contract Standing Order (CSO) 7.01(a) allows the Council to undertake procurement in this way as part of a group of public sector bodies provided the contract standing orders of one of the bodies are followed and that the final decision to award the contract award is made in accordance with the contract award provisions of CSOs.

10.3 Paragraph 3.3 notes that the Leader will approve the award of the contracts referred to in paragraph 10.2. CSOs allow for this. Although CSO 9.06.1(b) requires Cabinet approval for the award of contracts valued at £500,000, under CSO 16.02 the Leader may take this decision in between Cabinet meetings.

10.4 The recommendation in paragraph 3.4 of the report for the Leader to approve a new pan-London collaborative commissioning and cross-charging model is noted. Legal Services should be consulted before final sign off of the new model to ensure the Council's compliance with any applicable procurement rules.

10.5 The report is also seeking, at paragraph 3.6, approval for the extension of the Council's existing contract for provision of services to residents under options to extend provided for in the contract. Under CSO 3.01(c), Cabinet has power to approve contract extensions valued at £500,000 or more, as in this case.

10.6 The Head of Legal Services confirms that there are no legal reasons preventing Members from approving the recommendation in paragraph 4 of this report.

11. Equalities and Community Cohesion Comments

11.1 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;
- advance equality of opportunity between people who share those protected characteristics and people who do not;
- foster good relations between people who share those characteristics and people who do not

11.2 The Council will need to comply with the Equality Act 2010 in the provision of public health services and the NHS Constitution when making decisions affecting the delivery of public health in its area. The needs assessment has highlighted that some groups with protected characteristics suffer a higher burden of rate of STI's and we will have to clearly demonstrate that the proposed procurements will not have an adverse effect on any part of residents. It is intended that the proposed procurement will deliver better value for money whilst achieving better outcomes for services users and the whole community.

11.3 This report has been written at the stage where a business case has been developed by the LSHTP. The case for change uses both data and information from workshops with providers and services to both make the case and identify the change option.

11.4 The business case uses national data which provides information on age, sex, race, sexuality, gender reassignment, regarding level of attendances and the rates of STI; this can be broken down to some of the protective characteristic. Going forward the LSHTP has undertaken to produce an EQIA for the whole of the London programme; Hackney Council is producing the actual report with data intelligence from Islington Council. There are currently focus groups being held with key patient groups including an event for gay men and BME women. All Health Watch organisations in the participating 28 boroughs have been contacted and asked to work with the LSHTP to gain views from more residents.

11.5 The north central sub region will use this EQIA to inform its procurement strategy. Because the procurement process will allow for dialogue with potential providers the EQIA will be a live process, regularly reviewing how any model will affect residents' access. Review will include deeper analysis of data, some of which is held by the current north central London providers.

11.6 At the stage of seeking award of contract the full model will be apparent with a fully completed EQIA that is Haringey specific.

12. Use of Appendices

None

13. Local Government (Access to Information) Act 1985

None.