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ISLINGTON

HEALTH AND CARE SCRUTINY COMMITTEE

13 January 2015

SECOND DESPATCH

Please find enclosed the following items:

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Report to the Islington Health Scrutiny Committee

January 2015

PRIMARY CARE STRATEGY AND CO-COMMISSIONING

1. Synopsis

In recent months a number of policies and publications have been released which inform the overall direction of primary care and require CCGs to think through future plans. This includes the policy of primary care co-commissioning to share problem-solving and decision-making on primary care issues across CCGs and NHS England. In addition the North Central London Primary Care Strategy is in its last year of the agreed investment programme so we are currently refreshing the strategy across the five CCGs. The strategy will align with our co-commissioning plans as they need to support what we are trying to achieve in primary care.

This report sets out the new context for primary care and updates the Committee on progress with co-commissioning. It is an opportunity for the Committee to discuss and comment on plans prior to their formal approval by CCG Governing Bodies.

2. Recommendations

The Committee is asked to **consider** and **comment on** progress on plans for primary care across North Central London including co-commissioning. Some questions for the Committee have been indicated in the report but it would be helpful to have comments on the way forward for primary care in Islington more broadly.

3. Background

3.1 National and London Context

Over the past few months there have been some key policy announcements at a national and London level about how primary care is commissioned and delivered.

3.1.1 Co-commissioning

In May 2014, Simon Stevens (CE of NHS England) invited CCGs to come forward to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally, in part through co-commissioning. The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations.

Some of the possible benefits from co-commissioning:

- Improved provision of out-of-hospital services for the benefit of patients and local populations;
- A more integrated healthcare system that is affordable, high quality and which better meets local needs;
- More optimal decisions to be made about how primary care resources are deployed;
- Greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
- A more collaborative approach to designing local solutions for workforce, premises and IM&T challenges
- Co-commissioning is the beginning of a longer journey towards place-based commissioning

For this year, the scope of primary care co-commissioning is general practice services. The commissioning of dental, community pharmacy and eye health services is more complex than general practice with a different legal framework.

Through a national analysis of expressions of interest, it has become apparent that there are three main forms of co-commissioning CCGs would like to take forward:

Model 1: Greater Involvement
Greater involvement in NHS England decision making

Model 2: Joint decision-making
Joint decision making by NHS England and CCGs

Model 3: Delegated Arrangements
CCGs taking on delegated responsibilities from NHS England

NCL has expressed an interest in Model 2 Joint Decision-making in the first instance.

Further guidance about co-commissioning was published on 11th November (http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf). It sets out in more detail how co-commissioning will develop in each of the models. For joint commissioning, we will need to establish a joint committee or a committee in common with NHS England. We have the option to pool investment funds. Joint committees could cover the following functions:

- GMS, PMS and APMS contracts (design, monitoring, actions)
- Design enhanced services
- Design of local incentive schemes
- Approve practice mergers
- Making decisions on discretionary payments.

We will agree membership as part of the approval process but can include others e.g. Healthwatch and Health and Wellbeing Board representation as non-voting attendees.

The national timetable for co-commissioning is as follows:

<table>
<tr><th>Co-commissioning form</th><th colspan="2">Nov 2014</th><th>Dec 2014</th><th>January 2015</th><th>February 2015</th><th>March 2015</th><th>April 2015</th></tr>
<tr><td>Greater involvement</td><td colspan="7">Take forward arrangements locally</td></tr>
<tr><td>Joint commissioning</td><td colspan="3" rowspan="2">CCGs work with their membership and area team to consider and agree the preferred co-commissioning arrangement for 2015/16.</td><td>30 Jan: CCGs are invited to submit proposals to their regional office.

Please note that constitution amendments which relate solely to joint commissioning arrangements will also be accepted at this point.</td><td>NHS England works with CCGs to review and approve their submissions.</td><td>Local Implementation by CCGs with their area team</td><td rowspan="2">1 April: Arrangements implemented and go-live</td></tr>
<tr><td>Delegated commissioning</td><td>5 Jan: CCGs are invited to submit proposals to england.co-commissioning@nhs.net

During January, NHS England will work with CCGs to ensure that proposals are ready for sign off.

Please note that constitution amendments which relate solely to delegated commissioning arrangements will also be accepted at this point.</td><td>16 Feb: Proposals are signed off by an NHS England Committee (likely to be the proposed new Commiss-ioning Committee)</td><td>Local Implementation by CCGs and their area team</td></tr>
</table>

The approvals process is designed to be straightforward to support as many CCGs as possible to implement co-commissioning by April 2015. We are required to implement a short proforma and request amendments to constitutions.

3.1.2 NHSE Five Year Forward View and the London Health Commission Report

Both of these reports published at the end of last year strongly focus on the need for a sustainable high quality primary care landscape.

The Five Year Forward View includes the following:

- Stabilise core funding for general practice and review how resources are fairly made available
- Give CCGs more influence over NHS budget – investment: acute to primary and community
- Provide new funding though schemes like the challenge fund
- Expand as fast as possible the number of GPs, community nurses and other staff
- Design new incentives to tackle health inequalities
- Help public deal with minor ailments without GP/A&E
- Potential new care models such as Multispecialty Community Providers and Primary & Acute Care Systems

The London Health Commission Report includes the following:

- Increase the proportion of NHS spending on primary and community services
- Invest £1bn in developing GP premises
- Set ambitious services and quality standards for general practice
- Promote and support general practices to work in networks
- Allow patients to access services from other practices in the same networks
- Allow existing or new providers to set up services in areas of persistent poor provision.

3.1.3 London Strategic Commissioning Framework for Primary Care

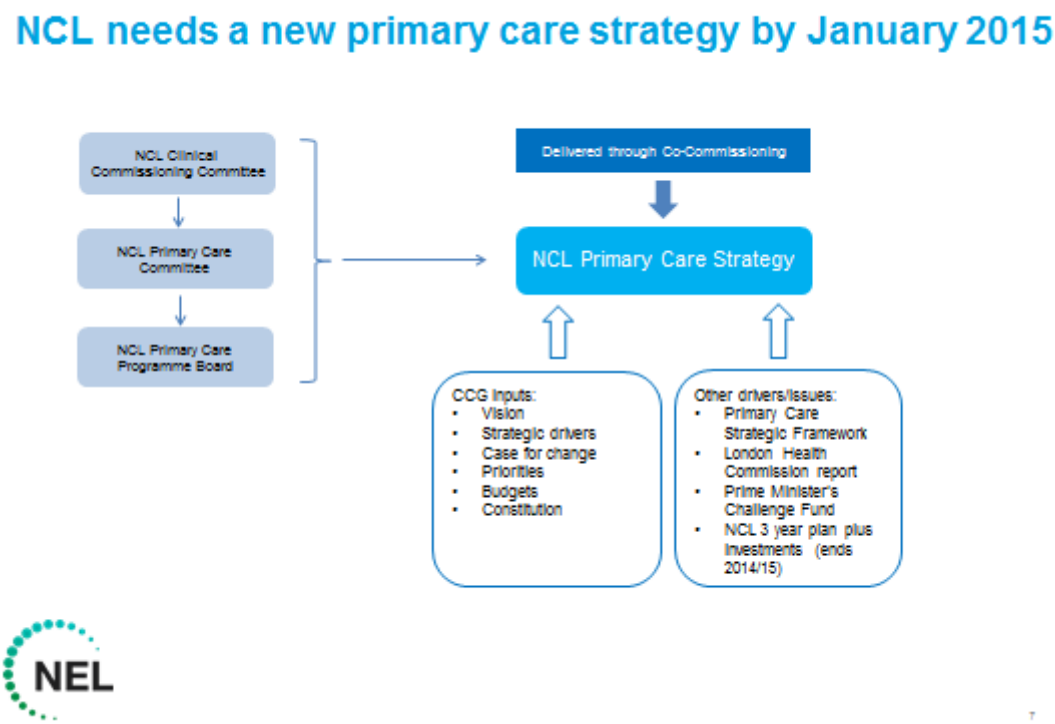
On 26th November the vision for high quality primary care for all patients in London is being launched for further engagement by NHSE with the support of CCGs. It covers specifications (service offers) based on the areas that patients and clinicians have identified as the most important:

Accessible care – better access primary care professionals, at a time and through a method that's convenient and with a professional of choice
Coordinated care – greater continuity of care between the NHS and other health services, named clinicians, and more time with patients who need it
Proactive care – more health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

This will have significant workforce and financial implications. CCGs in London will need to work through how to take forward the framework from April over a period of time.

4. North Central London Primary Care Strategy

Due to this changing context and in view of the pressures on general practice locally and the variable quality in some parts of the patch, North Central London (NCL) needs a refocused primary care strategy. We have been working over the past three years on developing primary care infrastructure and improving quality and access in line with the NCL Strategy. This has involved investment of c£12m per year from our pooled CCG funds. This commitment was for three years up to 2014/15. We need to be clear how we want this work to progress from the end of this year.



NCL has a strong track record in collaborative and mutually supportive working which will benefit the progression of the primary care development standards, and other initiatives such as co commissioning. As a starting point for refreshing the strategy have looked at local CCG plans and summarised our shared priorities for primary care development for NCL as follows:

- **Extending access to appointments**. This also includes work in making practices more productive and using information technology to enhance and improve patient care (e.g. interoperability, video consultations)
- **Ensuring GP provider collaboration and harnessing the benefits of working at scale** including development of GP networks to integrate with

other services (pharmacy, CHS, Specialist) to deliver personalised care for patients with complex long term conditions

- **Reducing variability and increasing the quality** of the offer to patients, enabling all patients to have fuller and more equitable access to services
- **Improving patient experi**ence and having in place a range of methods to be able to engage and get feedback from patients
- **Closing the gap on expected and observed prevalence** for long term conditions, and more proactive care of people with chronic diseases
- **Promoting self-care**
- **Integrating care better** and ensuring that primary care plays a key part in successful delivery of integrated and coordinated care
- **Taking a strategic approach to primary care premises development** and where appropriate trying to improve premises where primary and community services are delivered from
- **Supporting the primary care workforce** through planning, education and training to help deliver our strategic ambition for the transformation of services.

Based on these themes it is proposed that we refresh our primary care strategy for April 2015. This will be a joint primary care strategy for NCL that will broadly cover the following:

- Vision for primary care in NCL
- Implementation of the Co-commissioning Framework
- Response to the London Health Commission
- Key objectives for primary care across NCL.

Questions for the Committee

- ***Are the shared priorities above the right ones for Islington?***
- ***Bearing in mind the changing policy context, what opportunities are there for the development of primary care locally?***

5. Co-Commissioning Primary Care in NCL

In June 2014, the five CCGs in NCL submitted our expression of interest in co-commissioning and since then we have been progressing local discussions on a joint commissioning model. We have been clear that any collective co-

commissioning approach must mean that we can discharge that responsibility in a way that is better than now, and result in tangible patient benefits:

- The NCL Primary Care Strategy underpins the development of co-commissioning
- Gives CCG oversight of primary care development and how contributes to forwarding local strategic change
- More integrated decision-making
- Great consistency of outcomes and incentives
- Collaborative approaches to infrastructure developments (estate, workforce, IT).

We have identified some risks of co-commissioning which still need working through:

- Governance and handling of conflicts of interests: this will need careful and sensitive management. A national framework for conflicts of interest in co-commissioning is being published as statutory guidance in December 2014.
- Stakeholder and member views: Local CCGs need to continue to engage with their stakeholders and members to ensure they understand what we are proposing and what we are trying to achieve.
- Financial positions: Data on resources will need to be subject to transparent sharing and examination.
- Management costs: There will be no increase in running cost allowances and limited redistribution of NHSE resources under a joint commissioning arrangement.

The current approach in NCL is to set up a joint commissioning model over time with a shadow arrangement starting in April. This will give time to test out arrangements for decision making and membership as well as determine the resources needed.

Questions for the Committee

- ***Is the joint commissioning model the right one?***
- ***What should be the functions of a joint committee?***
- ***Who should be on the joint committee?***

Alison Blair, Chief Officer, Islington CCG
January 2015

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ISLINGTON

Corporate Resources
Town Hall, Upper Street, London N1 2UD

Report of: Director of Public Health

Meeting of:	**Date**	**Agenda item**	**Ward(s)**
Health and Care Scrutiny Committee	13 January 2015		

Delete as appropriate		Non-exempt

SUBJECT: SEXUAL HEALTH SERVICES IN ISLINGTON

1. Synopsis

1.1 Many sexual health services became the responsibility of councils in April 2013, as part of the transfer of public health responsibilities to councils under the health and social care reforms. This paper provides a background to levels of need and risks for sexual health in Islington, and the services commissioned. It focuses on those services which are the direct responsibility of the council, and outlines proposals for transforming local sexual health services. It also briefly highlights a number of new technological and service innovations.

2. Recommendations

2.1 The Health and Care Scrutiny Committee are asked to:

a) Note the importance and high level of sexual health need in Islington
b) Note the approach being taken in Islington to transform sexual health services, including collaborative working with Camden and other London councils on open access services
c) Consider the key risks identified.

3. Background

3.1 Open access sexual health services for Genito-Urinary Medicine (GUM) and Sexual and Reproductive Health/Community Contraceptive (SRH) services became the responsibility of local authorities in April 2013, as part of the transition of public health responsibilities to councils, together with sexual health promotion, HIV prevention and a number of other sexual health services. Other aspects of sexual health services are the responsibilities of Clinical Commissioning Groups (CCGs) (mainly for abortion) and NHS England (mainly for HIV treatment and care, GP contraceptive provision within the GP core contract and Human Papilloma Virus (HPV) immunisation). Public Health England published a guide in September 2014: Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV (full document) : the responsibilities of each commissioner are summarised on pp 11-13.

3.2 Islington has among the highest levels of sexual health needs in the country. Needs relating to the prevention and treatment of Sexually Transmitted Infections (STIs) and HIV are particularly high, with rates of the former more than double the national average and the latter four times. Gay, bisexual and other men who have sex with men (MSM) are particularly affected, as well as some BME groups. Needs around sexual and reproductive health, including abortions and repeat abortions, and continued action to prevent teenage pregnancy are also significant.

3.3 Islington commissions a range of services to meet the sexual health needs of local residents, and is also responsible for charges for Islington residents attending open access GUM services in other areas. Since many local services are open access, as well as meeting local population needs, sexual health services in Islington see a substantial number of residents from elsewhere.

3.4 Islington's sexual health budget is £8.631 million in 2014/15, accounting for over a third of the council's public health allocation. Open access sexual health services for GUM and SRH account for the largest share of the sexual health budget: with allocated budgets for GUM services of just over £5.272 million and SRH £1.260 million. Islington has the 5th highest attendance rate at GUM clinics in London. There were just over 39,000 attendances recorded in 2013. Local GUM services are provided by Central and North West London (CNWL) NHS Foundation Trust, which account for over 60% of GUM attendances by Islington residents. Other major GUM services used by Islington residents include Chelsea and Westminster, Imperial Healthcare, Guy's and St Thomas', Barts Health, The Royal Free London and The Homerton.

3.5 Other sexual health services commissioned by Islington include:

- young people's local sexual health services, currently being re-procured with Camden as a network of clinical services with preventive and clinical outreach;
- local and London sexual health promotion and HIV prevention programmes targeted to high need and vulnerable groups;
- services from GP practices (for HIV and STI screening; long acting reversible contraception (LARC)) and community pharmacies (Emergency Hormonal Contraception).
- a small number of psycho-social services for people living with HIV.

Relatedly, a 'club drug' clinic for residents of Camden and Islington called GRIP has been commissioned which sees referrals for residents from local sexual health services who may be at increased risk of HIV or other STI infection related to their drug and alcohol use.

3.6 A number of these services are commissioned from third sector or not-for-profit providers, as well as services from the NHS. Third sector providers include: the London HIV Prevention Programme, which consists of four third sector provider (as well as CNWL); Young People's Sexual Health services, provided by Brook and the Brandon Centre; and psycho-social HIV services including Positively UK and Wellness CIC.

3.7 During 2014/15, SHIP (Sexual Health In Practice) training is being offered to all GP practices in Islington to improve their skills in the recognition and assessment of risk and the offer of testing. This programme has been shown to increase the diagnosis of HIV among patients, and to be particularly

effective in reaching people from African communities helping to reduce late HIV diagnoses.

3.8 Locally, a sexual health network of stakeholders is being developed to help improve local sexual health, develop a more coordinated and collective approach to addressing key sexual health challenges, and inform the development of local services: this is still in its early stages – the second meeting was held in December, and a third is being scheduled for February. Membership includes local and London commissioners, NHS and third sector sexual health services, GP and other stakeholder representatives. It is expected that this engagement will develop further through the coming year and the intention is to develop service user engagement through this forum, either directly through service user group representatives or through other means such as surveys, etc.

3.9 **Effectiveness of current services**

Measures of effectiveness of services include population level indicators for the overall sexual health of the local community and specific service level performance indicators, based on recognised clinical standards.

3.10 **Population indicators**

Islington has very high levels of sexual health needs and morbidity. These are reflective of a variety of factors, including: high levels of deprivation; local population mix (a relatively young, ethnically diverse and single population, including a significant LGBT population); and geographic location - being located in inner London which generally has high levels of STIs and HIV infection compared to the rest of England.

3.11 Islington's rate of STIs in 2013 was 1,949 per 100,000, ranked 5th in London and more than double the national average of 810 per 100,000. Islington has seen significant increases in sexually transmitted infections reported since 2008, when a new national recording system was introduced, with a particularly marked increase in gonorrhoea, as well as syphilis and chlamydia. For all 5 major (non-HIV) STIs, which also include warts and herpes, Islington is in the top 10% of local authorities nationally: MSM account for just under half of all STIs among Islington residents, and account for a particularly significant share of gonorrhoea and syphilis infections. Recent trends in Islington have been similar to London as a whole, including a slight reduction in the overall level of STIs between 2012 and 2013. In common with many other London areas, Islington has seen a reduction in warts diagnosed through GUM clinics. This is likely to be linked to the introduction of HPV vaccination, and indicates the health benefits to local residents of further increasing uptake. Local uptake is currently just above the London average, at 80%, but compares to a national average of 86%.

3.12 Diagnosed HIV at 8.5 per 1,000 population aged 15-59 is four times higher than the national average (2.1 per 1,000). MSM account for just under 70% of local diagnosed HIV infections and heterosexual men and women account for just under a quarter, with some African communities particularly affected. In 2013, Public Health England reported an HIV testing rate of 68.1% among eligible GUM attendees who were Islington residents, below the national average of 71%. This indicates the potential to increase testing uptake among GUM clinic attendees, although the local Key Performance Indicator data from the local provider (shown in Appendix 1) indicates substantially higher uptake in local services in 2014/15.

3.13 There are a number of factors which mean that recent trends in infections need to be interpreted with some caution:

- new, more sensitive tests and changes in clinical guidelines will have increased diagnoses of some infections, for example of gonorrhoea;
- there has been a substantial increase in HIV testing in GUM services over the past 5 years;
- the impact of a new national reporting system, including improvements in the recording of sexual orientation.

On balance, it is likely that changes in guidelines, new tests and increased testing will have contributed a significant part of the recent changes in STI and HIV diagnoses, though by no means all of the increase. However, at the very least the data is consistent with high and continuing levels of need and

risk around HIV and STIs in Islington; it highlights in particular concern about levels of need among gay, bisexual and other men who have sex with men.

3.14 Against this backdrop of high levels of sexual health need, population level sexual health indicators in the Public Health Outcomes Framework (PHOF) show:

	Islington	London	England
Under 18 Conceptions (rate per 1,000 15-17 year old young women) (2012)	30.1	25.9	27.7
Chlamydia detection rate (per 100,000 16-24 year olds) (2013)	2,048*	2,179	2,016
People presenting with HIV at a late stage of infection (as a percentage of all newly diagnosed infections)	31.8%	44.9%	48.3%
HPV vaccination coverage (completed doses in girls aged 12-13) (2013)	80.2%	78.9%	86.1%

* Levels of chlamydia diagnosis in Islington residents aged 16-24 are below the level (2,300 per 100,000) indicated by Public Health England where it would be expected to impact on the underlying prevalence of the infection (which may otherwise go undetected). Further improvements, for example through the young people's sexual health network and improved detection in primary care, would be expected to have further impact over time.

3.15 As well as the above PHOF indicators, abortion rates and repeat abortion rates, also represent key measures of population sexual health. Overall, the abortion rate in Islington is the one of the lowest in inner London, with a rate of 20.7 per 1,000 women aged 15-44 in 2013 but is higher than the national average of 16.6. Just over a third of abortions among 16-24 year olds are repeat abortions, which is substantially higher than the national average.

3.16 Access to Long Acting Reversible Contraception (LARC) is another important indicator for access to effective methods of contraception and as a measure for choice. Prescribing of LARC through general practice in Islington is the one of the lowest in the country, and in general is low across almost all London boroughs. In 2013, the rate of long acting reversible contraception (LARC) per 1,000 women prescribed in primary care in Islington was 18.1, compared to 52.7 per 1,000 women in England. This may reflect, at least in part, a preference for GPs to refer to, or for patients to use, community contraceptive services which are well developed locally compared to many other areas. Community contraceptive services report a marked shift towards use of LARC among patients, including among younger women. The introduction of new integrated national datasets for contraception may assist with better assessing this in future.

3.17 **Service level indicators**

A number of evidence-based indicators for service effectiveness have been introduced as part of service specifications for open access sexual health services. The indicators for GUM are attached as Appendix 1, together with data against the indicators for the major local GUM service, CNWL (based on Month 7 reports). A comparison with service standards and clinical guideline indicators, shows that:

- the offer and uptake of HIV testing meets national standards;
- local partner notification ratios for follow-up of contacts of people diagnosed with gonorrhoea or chlamydia exceeds national standards;
- the 48 hour access target has been met throughout 2014/15 year to date, against a minimum standard of 98%.

As well as routine data reporting, included in the table, a number of indicators will be assessed through audit, such as for the uptake and completion of Hepatitis B immunisation among eligible MSM, and auditing the new standard on notification of test results within 10 days.

3.18 **Open access sexual health services (GUM and SRH) – current arrangements and transformation proposals**

3.19 **Current commissioning arrangements for open access sexual health services**
Prior to the transition of public health services to the Council, GUM services were purchased by NHS commissioners using a centrally mandated tariff. The local NHS commissioner was the 'host' commissioner for the service, but NHS commissioners were responsible for paying for their own residents wherever the open access service was attended. There was a single tariff used regardless of the sexual health service delivered to the patient.

3.20 The transition to councils ended this NHS system of centrally mandated prices and 'host' commissioning, replaced by a mandate to councils for open access sexual health services and guidance from the Department of Health on cross-charging. Particularly in London, with significant movements of residents across borough boundaries, an effective commissioning arrangement for cross-boundary, open access services is important in order to reduce financial and service risks for both commissioners and service providers. SRH services locally have remained under a 'block' commissioning arrangement, with agreed minimum activity levels and service quality indicators.

3.21 Islington joined an alliance of 12 London councils to negotiate 2014/15 contracts with major and other local GUM providers. As part of this alliance, Islington negotiated this year's GUM agreement with CNWL on behalf of the 12 London councils. Similarly, other councils negotiated agreements with their local GUM services on behalf of the alliance of councils. This collaborative working has introduced cost controls and greater consistency in quality as part of annual contract negotiations with trusts. This has included removing the GUM services from historic NHS contracts and implementing revised specifications, Key Performance Indicators (KPIs) and changes in payment terms. A crude estimate is that these measures taken together have reduced the average unit cost by 12% compared to use of the national non-mandatory tariff published by the NHS, which is equivalent to around £600,000 a year on the current budget for GUM services. This has helped to manage and contain costs in the context of increasing activity. A similar approach is planned for 2015/16.

3.22 **Islington's Public Health Transformation Programme for Sexual Health**
Islington is working with a number of other London councils to develop proposals for two major transformation initiatives. These have been primarily focussed on open access GUM services, but will also affect SRH services. These initiatives involve:

- developing a new integrated sexual health tariff across London which could be used in the future commissioning of services; this is intended to more closely match commissioner spend to the services needed and used by patients, based on clinical guidelines and what it should cost services to deliver interventions against those guidelines;

- participation in a London sexual health services transformation programme to develop proposals for the future design and re-commissioning of open access sexual health services.

These two programmes are intended to be important in achieving a clinically and financially sustainable model for open access sexual health services. This is in the context of significant annual growth in GUM service activity in recent years, in the range of 4-8% per annum, as well as the need to achieve improved outcomes, such as through promoting HIV testing to reduce new HIV infections and late diagnoses. The integrated sexual health tariff would also be expected to help to reduce the variation in contraceptive provision between GUM services in London under the current funding system, promoting a more integrated service offer for service users, as well as innovation among services.

3.23 Working collaboratively with other councils on these transformation proposals recognises the impacts that local decisions can have in an open access system, and is intended to promote a coordinated approach across neighbouring local authorities where it demonstrates benefits for residents. It should also bring greater opportunities for assuring quality and standards for Islington residents using open access services elsewhere in London and for achieving Best Value through collaborative commissioning approaches.

3.24 **Changing how services are funded: the Integrated Sexual Health Tariff**
This is a London-wide project which is underway to develop a payment approach to service providers which more closely reflects the level of clinical service needed by patients, according to national clinical standards. It is intended to help to drive efficiency and innovation on the part of providers and realise substantial savings for commissioners.

3.25 At present, open access GUM services are paid for by a simple first and follow up tariff paid for GUM attendances. This does not distinguish between levels of patient need or the services provided. For example, the tariff payment does not differentiate between a patient presenting with a significant history of risk and a complex sexually transmitted infection compared to a patient with little risk seeking an HIV test for reassurance or peace of mind. Open access SRH services have been covered under 'block' contract arrangements. Previous work carried out by the NHS in London in 2010-11 indicated that the cost for trusts to deliver sexual health services were in most cases substantially less than the price paid by commissioners under the national NHS first and follow-up tariff; at the same time the exclusion of contraception from the national tariff led to a variable contraceptive offer for patients.

3.26 The integrated sexual health tariff proposal draws on this previous work, which involved clinicians and commissioners in the development of costed pathways for GUM and Sexual and Reproductive Health Services based on clinical guidelines. All councils in London are currently collaborating together on an update of the tariff programme. Clinicians and trusts are also involved in the current London refresh. The refresh involves:

- updating pathways to reflect changes in clinical guidelines
- updating service costs from the original 2011 work
- collecting current activity data from sexual health service providers across London in order to re-model costs and impacts on services and commissioners
- risk and sensitivity analyses to assess the potential impacts of changes on both commissioners and providers.

Previous estimates of the impact of introducing an integrated sexual health tariff from 2010/11, indicated that Islington as commissioner would have expected to make savings of around £1.5 million at that time. A number of trusts in London on the same estimates were projected to see reductions of 30% or more in income for open access sexual health services, reflecting the difference between funding under the current system and the costs of services delivered under the integrated tariff. The major local provider, CNWL, would have been expected to fall into this category. This indicates that there was a substantial difference between what commissioners were paying and what it was costing trusts to provide: in essence, the integrated tariff would represent a fairer system of remuneration between commissioners and services, based on clinical guidelines.

3.27 The updated tariff work is expected to report by May 2015, at which point it will be possible to take stock of the findings and the implications for commissioners and services, including of the risk and sensitivity analyses. It is not proposed to implement the new tariff until 2016/17 – this is intended to allow a year to 'shadow' the new tariff with trusts as well as to identify and work through any aspects of the tariff that require further adaptation or adjustment. In doing so, it is recognised that there are potential risks as well as benefits through changing the funding. There is a need to carefully assess the risks and manage the introduction of any changes working with services and trusts. Officers will also be working closely with all providers across the participating boroughs to get an early indication of any possible risks or impacts.

3.28 **London Sexual Health Services Transformation Programme**

In addition to the development of an integrated tariff, there is also work underway across a number of London councils to develop proposals for new, and more cost effective, models of sexual health service. This is intended to help facilitate a more collaborative approach to commissioning sexual health services across London, which, if agreed, would be expected to be implemented from 2017/18. It is anticipated that this work will consider a range of options including opportunities offered through new technologies (e.g. home STI testing), new service models, use of on-line services and changes in clinical staffing skill mix, among others. These will deliver services that engage with how young people

and adults increasingly access and use services, taking into account changes in sexual health needs and trends. As such, engagement with service users, clinicians and other stakeholders will be key to developing proposals for future models.

3.29 The London Sexual Health Services Transformation Programme is a phased programme involving 20 London councils, mainly in North and inner South East London, which together account for about 72% of GUM resident attendances in London and whose local services see 78% of all GUM clinic attendances in London. The programme is developing proposals for a new service model for Level 3 GUM clinics (Level 3 GUM services are those services able to provide all aspects of care for the screening, diagnosis, treatment and follow-up, including partner notification, of STIs and testing for HIV, including complex infections), however the proposals are intended to be developed fully in the context of the wider sexual health system, whether these are other services commissioned by councils, CCGs or NHS England. The first phase completed in November. It produced a Case for Change based on a process of engagement with the councils and commissioners, supported by a needs analysis and evidence review of service models, interventions and relevant guidelines.

3.30 The Case for Change sets out a number of important challenges for the future commissioning of sexual health services. The major challenges include:

- high levels of need and increasing activity across London;
- the need to improve key population outcomes, such as preventing HIV and other STIs or improving earlier HIV diagnosis;
- the need for commissioners to proactively shape and re-specify service models, ensuring quality and value for money;
- assuring the quality and clinical governance arrangements for services used by residents in an open access system;
- the dual challenges of reaching a clinically and financially sustainable service model for the future.

The underpinning evidence review has pointed to the importance of a linked-up system for clinical services and patient experience operating as a network around Level 3 services, providing open access services and signposting/access to other services where needed. It considered studies of the use of new on-line/digital and home sampling/testing technologies as well as to other service models that are emerging (e.g.new community pharmacy models, etc). The review pointed to significant changes in sexual behaviour/lifestyles in the population, and changes in how people are accessing and using services. Additionally, national policies and guidelines are encouraging more regular testing and increased emphasis on the role of earlier diagnosis and treatment as part of prevention efforts, including in efforts to reduce long term trends in new HIV infections.

3.31 With the completion of this phase of the Transformation Programme, the second phase will concentrate on developing the business case and service model proposal. It includes a programme of engagement with stakeholders, including clinical and service, service user, resident and third sector and other stakeholders in contributing to the development of the model and outcomes. It is expected that this model will have been developed by early Summer 2015. It can be expected that this will stipulate clinical quality and service standards, including the 48 hour access target, and to identify other requirements around patient experience within any new model, for example around privacy. Additionally, standards around safeguarding, including sexual exploitation and domestic violence, would be included and consideration given to the inclusion of other interventions, such as brief interventions for excess alcohol use, which contribute to clinical and patient care.

3.32 **Key Risks**

There are three key risks identified at this stage of the transformation programme initiatives.

(a) How NHS trusts may react to changes in income associated with a new tariff system – in particular whether trusts may react by reducing access or services, or increase activity in order to increase income (for example, by offering routine STI screening to more low risk SRH patients). The tariff refresh will include risk and sensitivity analyses to assess the impact of changes on both commissioners and providers of services, and it should be possible to run a

shadow arrangement for a period to identify problems or adjustments that may need to be made. Additionally, payment of the new tariff will be based much more closely on the services provided against clinical guidelines than the current system which will mean that trusts will be encouraged to innovate rather than reduce services.

(b) That increases in activity will continue at current or faster rates in the longer term – which may mean that it becomes progressively more difficult to fund services. Current measures include working as an alliance with other councils to negotiate lower tariff costs, together with financial control measures such as marginal rates on growth and in-year monitoring of activity and costs. In the medium term, it can be anticipated that the integrated sexual health tariff should lead to savings for commissioners, which will assist with managing any future activity changes.

(c) The challenges of sustaining collaborative working across a large number of councils – which may mean that it may be more difficult to realise some of the benefits envisaged in the local proposals. The London sexual health service transformation programme is led by a Council Chief Executive, which provides strong leadership to the programme.

3.33 **Young people's sexual health services**

As well as participation in the London transformation work described above, Islington has jointly re-developed and re-procured **young people's sexual health services** with Camden over the past year. Such services have been important in significantly reducing teenage pregnancy rates locally. Young people and young adults (ages 15-24) comprise a significant part of Level 3 GUM activity (around a third in Islington). The provision of community services, with a particular focus on prevention and outreach with vulnerable groups and in non-specialist settings, has the potential to reduce current and future risks, as well as providing screening and contraceptive services outside of a Level 3 setting, which may help to manage future demand for these services.

3.34 The young people's sexual health network will be expected to help improve patient experience, as well as addressing a number of key indicators for better sexual health in the borough: this will involve moving to a three site model across Camden and Islington to support consistency of service offer across sites (Camden/borders/Islington) supported by a greater emphasis on preventive and clinical outreach into other young people's settings, including targeted services.

3.35 The new networked model has been informed by feedback, survey information and other engagement activities with young people and service users around preferences and service experience in both boroughs. It also drew on findings from a number of initiatives such as the 'You're Welcome' quality criteria assessment for young people's sexual health services and mystery shopping involving young people. Young people were involved in the assessment of service bidders as part of the procurement. A brief description of the new network is included as Appendix 2.

3.36 **Sexual Health Promotion and HIV Prevention**

As well as the young people's services described above, Islington commissions a strong Healthy Schools programme and prevention services from the London HIV Prevention Programme and from CNWL. The London programme is funded with other London councils, following a major needs assessment and review carried out in 2013, and the local prevention programme includes services commissioned with Camden and Westminster.

3.37 High quality SRE in primary and secondary schools, and other educational settings, are an important cornerstone of promoting good sexual health, and is associated with delay in age of first sexual intercourse with increased use of condoms/contraception. This continues to be a major focus of the Healthy Schools Programme in Islington, and has made an important contribution to actions on significantly reducing teenage pregnancy rates in the borough.

3.38 The London HIV Prevention Programme provides a mix of interventions targeted to MSM and African communities, including media communications, condom distribution and some outreach, and includes

an accompanying evaluative programme to develop increased insight from the programme interventions into how to better meet changing needs. In January, the programme will launch a major HIV testing promotion campaign across London aimed at these two groups.

3.39 The local prevention programme includes work with MSM; African communities; sex workers, street homeless and other vulnerable groups (the CLASH service); and young people. From April next year, the young people's work will be part of the new young people's sexual health network. The local programme provides a mix of interventions, including 'clinic in a box', outreach and promotional activities; there is also an accompanying condom distribution scheme for GP practices and other settings. The programme aims to promote good sexual health, prevent HIV and improve access to services, including uptake of testing. Public Health is currently reviewing the evidence base around the service, drawing on the pan-London gay men's prevention for MSM and reviewing the evidence for other groups, with a view to updating and re-specifying the service model. This will also need to consider what actions around accompanying alcohol and drug use could be incorporated into the service model. It is expected to realise some savings as part of this re-specification through achieving more effective services and better value for money.

3.40 **New services and technology**

Sexual health services currently represent a fast changing field, encompassing changes in clinical guidelines, pathology tests, treatments and other technological and service innovations.

3.41 The main service model innovation identified through the London Transformation Programme relate to the potential for the use of on-line/digital access for preventive advice and testing services, linked to the use of home sampling. This is a still small but fast developing field – there are a number of initiatives underway or being piloted in London currently, as well as international studies looking at on-line access. Islington has expressed interest in being involved in a new London on-line HIV home sampling service, being coordinated through Public Health England. Studies have demonstrated acceptability for users and a cost per positive diagnosis which falls well within cost-effectiveness ranges. If HIV testing is to be promoted more widely, for example, then it is likely that it will require such approaches which are able to increase access and reach but to do so in more cost effective ways. Similar technologies are underpinning 'clinic in a box' and other preventive outreach activities, and there may be opportunities to integrate a sexual health testing service offer into other services for vulnerable groups, such as services for the homeless or drug and alcohol services in the future, although these are likely to be longer term potential developments.

3.42 In the field of vaccination, the government's independent national advisory Joint Committee on Vaccination and Immunisation (JCVI) is currently consulting on new guidance on the introduction of HPV vaccination for people with HIV and for MSM in GUM clinics. In 2015, the committee will also start work on assessing the case for extending the current HPV vaccination programme for school-aged girls to include boys.

3.43 The other major intervention, currently the subject of several international and national studies, is Pre-Exposure Prophylaxis (PrEP). This is the use of anti-HIV drugs by people without HIV to prevent or reduce the risk of HIV infection. Combined with other anti-HIV prevention measures, it has the potential to substantially reduce the risk of HIV transmission among groups at high risk of HIV infection. However, PrEP raises a number of important issues including cost/resource implications, long term sustainability and impacts (including the need for long term adherence, potential toxicity and other long term health effects; risk of viral resistance) and whether the potential protective benefits of PrEP are outweighed by other behaviour changes (e.g. risk of reduced use of condoms or increased levels of STIs).

4. Implications

4.1 **Financial implications:**

Islington Council receives a ring-fenced Public Health grant from the Department of Health to fund the cost of its Public Health service. The total funding for 2014/15 is £25.429m. The sexual health budget in

2014/15 is £8.631 million in total.

GUM services are mandatory open access services within Sexual Health that are demand-led with increasing levels of activity in recent years. Islington has an obligation to pay for activity irrespective of whether a contract is in place or not and tariffs exist for these purposes. This contract should not create a budget pressure for the Council. Although there is a contract in place there is still a risk of a pressure based on an increase in activity.

The current budget earmarked for the Sexual and Reproductive Health service is £1.260 million per annum. It is funded through a block contract, agreed annually, and should not create a budget pressure for the Council.

The Council's Public Health expenditure must be contained entirely within the grant funded cash limit indicated above. If any additional pressures are incurred management actions will need to be identified to cover this.

4.2 **Legal Implications:**

The council has a duty to improve public health under the Health and Social Care Act 2012, section 12. The council must take such steps as it considers appropriate for improving the health of the people in its area including providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way) as well as providing services or facilities for the prevention, diagnosis or treatment of illness (National Health Service Act 2006, section 2B, as amended by Health and Social Care Act 2012, section 12 and Regulation 2013/351 made under the National Health Service Act 2006, section 6C). Therefore the council may provide specialist sexual health services as described in this report. . The council may enter into contracts with providers of such services under section 1 of the Local Government (Contracts) Act 1997.

4.3 **Environmental Implications:**

There are no direct environmental implications expected from Islington's sexual health programme at this stage. Of the two major transformation initiatives, it is unlikely that the integrated tariff would have environmental implications. There is a possibility that the London sexual health services transformation programme might have implications, but this will be assessed as part of the development of more detailed service model options.

4.4 **Resident Impact Assessment:**

Resident and equality impact assessments will need to be carried out as part of the development of proposals on the integrated tariff and the London Sexual Health Services Transformation Programme. Analysis from local needs assessment particularly highlight the importance of sexuality, gender, age, ethnicity and deprivation in local sexual health needs.

5. Conclusion and reasons for recommendations

5.1 Islington has high levels of sexual health needs among local residents. Open access services for GUM and SRH are important parts of effective action to improve sexual health, mandated in the Public Health Grant conditions, together with a range of universal and targeted sexual health promotion and HIV prevention interventions. Commissioning open access services in London and ensuring that programmes reach key groups, with significant cross-boundary flows between boroughs, present particular challenges for commissioners and public health interventions.

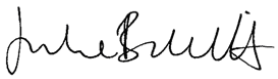
Islington is working collaboratively with a number of other councils to develop initiatives for clinically and financially sustainable services for the future, whilst working jointly with Camden on refreshing and redeveloping its young people's and sexual health promotion and HIV prevention services.

Appendices
Appendix 1: GUM Commissioning 2014-5: Key Performance Indicators (KPIs) and other metrics
Appendix 2: The new model for Camden and Islington Young People's Sexual Health Network

Background papers: (available online or on request)

Final report clearance:

Signed by:



Director of Public Health Date 5 January 2015

Received by:

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Appendix 1: GUM Commissioning 2014-5: Key Performance Indicators (KPIs) and other metrics

This is a proposal for KPIs and Other Metrics for GUM services as part of the 2014-5 contract with local authorities in the West London Alliance GUM collaborative,

1) **Key Performance Indicators** draws from indicators in the 2014 BASHH[1] standards, with high level targets for service access and quality and allows for benchmarking against BASHH standards and national (or London) averages where they exist.
2) **Other metrics** are indicators that provide a deeper understanding of particular services. These are not associated with meeting specific national standards, but can be useful in providing a comparative view of different services and population needs.

Key Performance Indicators

Number	Domain	Indicator	Definition Issues	Target (BASHH standards unless stated)	CNWL (Month 7)
KPI 1	Access	% of people with needs relating to STIs contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service.	Relates to patients seen in Level 3 GUM services or seen purely under a GUM tariff	98%	98%
KPI 2	HIV Testing	% of people with needs relating to STIs who are offered an HIV test at first attendance (excluding those already diagnosed HIV positive).	Excluding those when not appropriate (use PHE methodology)[2]	97%	97%
KPI 3		% of people with needs relating to STIs who have a record of having an HIV test at first attendance (excluding those already diagnosed HIV positive).	As per PHE methodology	80%	80%
KPI 4	Partner Notification	Contactable contacts of index cases of gonorrhoea who have been notified either by the service or the index case within four weeks of the date of first PN discussion.		0.4 contacts per index case	1.38
KPI 5		Contactable contacts of index cases of chlamydia who have been notified either by the service or the index case within four weeks of the date of first PN discussion.		0.6 contacts per index case	1.18
KPI 6	Timely	% of people having STI tests who can access their results		95%	Audit

[1] British Association for Sexual Health and HIV

[2] H1, H1A, H1B, P1A and T4 in the numerator and the same set of codes together with P1B (offer of test declined) in the denominator

	notification of results	(both positive and negative) within ten working days of the date of the sample (excluding those requiring supplementary tests).			

Other Metrics

Emphasis that these are not about clinic performance per se but understanding context in which they operate

Number	Domain	Indicator	Definition Issues	CNWL (Year to date, M7)
1	Timely treatment	% of people who having positive STI tests who present for follow up within 10 working days		Audit
2a	HIV	New diagnoses of HIV	New diagnoses in service (not transfers in)	100
2b		Late diagnoses of HIV (CD4 count below 350 cells/mm^3)		30%
3a	Health Promotion	% of eligible MSM and sex workers offered Hepatitis B testing	% patients offered / % eligible patients	Patient note Audit
3b		% of eligible MSM and sex workers taking up Hepatitis B vaccine	% take up / % offered	Patient note Audit
4	Patient Experience	'How likely are you to recommend this service to someone you know if they needed similar care and treatment?' Extremely likely, Likely, Neither likely or unlikely, Unlikely, Extremely unlikely, Don't know All users attending the service over a one-week period (each quarter) with a quick feedback card which contains this question and uses these responses to identify how well the service is performing.	Net Promoter score The FFT/net promoter score result = [Unrounded % for Extremely Likely] – [Unrounded % for neither likely nor unlikely + Unlikely + extremely unlikely].	Net promoter score: 74

5	Residence	% of attendees with no postcode (LSOA) information		2.1%

Appendix 2

The new model for Camden and Islington Young People's Sexual Health Network

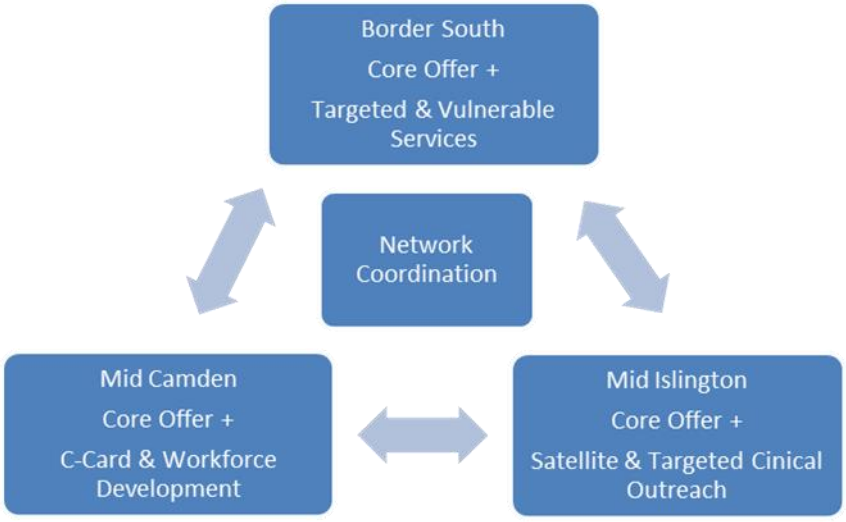
- Three sites providing the core offer (Level 1 and 2 integrated sexual health clinic, SRE in schools and health advice and counselling) one Islington based, one Camden based and one border based)
- Specialisms operating across both boroughs
  - Satellite Clinics and targeted clinical outreach
  - Vulnerable / Targeted Health promotion & relationships support
  - C-CARD Condom Distribution & Workforce Development

Clinics will provide open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections, according to evidence-based protocols and adapted to the needs of local populations.

Young People's Sexual Health Network Coordination

The coordinating function will support shared outcomes and a seamless pathway, cooperation and partnership working, better identification of young people at risk, improved outcomes through better reach and coverage and less onward referrals outside of the network. This will also provide a streamlined commissioning and contracting framework, with all providers represented through network co-ordination.

By agreeing to work within this network model, providers commit to collaborating with all other providers within the network, through the network coordinating function.



Delivery Period: 1ST April 2015 to 31ST March 2018, with option to extend up to a further 2 years and an additional 2 years as appropriate.

Key Service Outcomes

The service will support delivery against the three main sexual health Public Health Outcome Framework[3] measures for younger people up to the age of 25 years:

- Under 18 conceptions
- Chlamydia diagnoses (15-24 year olds)
- People presenting with HIV at a late stage of infection

It will also deliver the following outcomes to improve the sexual health in the local population as a whole:

Aims	Outcomes
Young people have information and skills to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual health and well-being	• Improved knowledge and skills of children and young people • Reduced Teenage conceptions • Increase in chlamydia and gonorrhoea screening
Reduce unwanted pregnancies for women aged under 25 and in particular for teenagers	• Reduced teenage conceptions • Reduced teenage abortions • Reduced teenage repeat abortions • Increased number of young women choosing LARC
Reduce the burden of sexual ill health in young people through early diagnosis, and rapid access to treatment	• Increased chlamydia diagnosis • Reduced Pelvic Inflammatory disease related admissions
Young people's wider needs are identified and appropriately addressed when they engage with health providers around their sexual health	Including: • Appropriate pathways with TOP services • Appropriate referrals to safeguarding • Appropriate referrals to substance misuse teams and other youth services

In addition it is intended for the young people's network to:

- Increase access to services whether clinic based or through outreach for young people with the highest levels of risk
- Increase access to HIV and viral hepatitis testing for young people at risk
- Provide services in a way that is appropriate to young people in accordance with You're Welcome principles
- Provide services at locations and times which meet the needs for young people from across Camden and Islington
- Reduce the need for young people to access specialist Level 3 GUM and contraception services unless clinically indicated
- Work collaboratively with young people, both users and non-users of the services to review and evaluate the offer in order to increase and align the offer to the needs and preferences of young people