Open Agenda

Health and Wellbeing Board

Thursday 29 January 2015
10.00 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London
SE1 2QH

Supplemental Agenda No. 1

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Date: 26 January 2015

Agenda Item 14

Item No. 14.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Safeguarding Adults Board Report 2013-2014	
Wards or groups affected:		All	
From:		Deborah Klee, Chair of Southwark Safeguarding Adults Board	

RECOMMENDATIONS

1. The board is requested to note the Annual Southwark Safeguarding Adults Board Report (Appendix 1 of the report).

EXECUTIVE SUMMARY

2. The Annual Report is due to be presented to the Scrutiny Sub-Committee on 27 January 2015.

3. The Annual Report was agreed by the Safeguarding Adults Partnership Board in January 2015. The Board includes representatives from the local authority, NHS, Metropolitan Police, and community organisations.

4. Statutory guidance No Secrets (2000) requires the Local Authority to convene a Safeguarding Adults Board to determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress in achieving stated aims and objectives. The Board has an independent chair. The current chair has been in post since January 2014 and this is her first annual report to the Board.

5. This report is one of the methods whereby the Safeguarding Adults Board enables challenge and transparency across the multiagency partnership in Southwark. This report relates to the work of the Board and its partner agencies in the year 2013-2014. Agencies represented on the Board have contributed to the writing of the report and have commented on the final draft.

BACKGROUND INFORMATION

6. The report provides information on the activity and effectiveness of the Safeguarding Adults Partnership as it has responded to both national initiatives and legal changes and local circumstances in order to better safeguard adults at risk in Southwark.

7. The report describes how the Southwark Safeguarding Adults Partnership has responded to the demands of the Care Act 2014. It outlines the local initiatives to deliver local care to people with learning disabilities who challenge services that the Winterbourne Hospital Review and Concordat requires. The report also describes the local initiatives to promote compassionate care demanded by the Francis report on Mid-Staffordshire Hospital.

8. The report includes details of the quality strategy for residential and nursing care homes developed by the Safeguarding Partnership in conjunction with My Home Life and provider partners.

9. 2012 – 2013 highlighted a comparatively high percentage of alleged abuse carried out by social care workers in Southwark. As a result of the quality strategy and better monitoring of care provided in care homes and the person's own home numbers of allegations of abuse by social care workers have fallen by 4% and are now below the national and comparator group median.

10. In April 2013 local authorities became the statutory supervisory body for all Deprivation of Liberty Safeguards (DoLS) authorisations. In March 2014 the Supreme Court gave additional clarification of DoLS which effectively widened the circumstances under which a person could be seen as being deprived of their liberty. This led to an immediate significant increase in referrals for authorisation. This challenge will continue.

11. A multi-agency thresholds document has been produced by the Safeguarding Adults Team to assist staff in determining whether allegations are should become safeguarding enquiries. This was adopted by the Board in March 2014

12. Arrangements have been put in place to ensure the 2014-2015 annual report will be produced and circulated earlier.

KEY ISSUES FOR CONSIDERATION

13. This report outlines development areas for the coming twelve months to improve the work of the Board and ensure compliance with the Care Act 2014. These are:

- Develop Three Year Strategy and annual work plan for the Safeguarding Adults Board.

- Establish subgroups with realistic work plans to deliver the work required.

- Ensure partners and providers are aware of the widening of the Deprivation of Liberty Safeguards Criteria and create resources to deal with the increased workload including training more qualified best interest assessors.

- Ensure all partners and providers are aware of their wider responsibilities under the Care Act 2005 (e.g. best interest decisions) through provision of appropriate training in all sectors, such that the Board is in a strong position to take on its statutory role in 2015.

- Develop a protocol and forum for joint work with the Southwark Safeguarding Children's Board, the Safer Southwark Partnership and the Health and Well-being Board.

- Carry out a qualitative and process audit of safeguarding adults practice.

Policy implications

14. This report is before the Health and Wellbeing Board for the purpose of compliance, information and challenge.

15. The work of the Safeguarding Adults Board is consistent with the Council's Farer Future priorities as stated in the four-year Council Plan.

Community and equalities statement

16. The work of the Safeguarding Adults Board particularly affects adults at risk/vulnerable adults and their families. It is a partnership set up under statutory guidance to ensure effective safeguarding of adults at risk in Southwark and ensure accountability of partner agencies.

Legal implications

17. The Safeguarding Adults Board is set up under statutory guidance contained in No Secrets (2000). From April 2015 it will be at statutory board as a result of provisions contained within the Care Act 2014.

Financial implications

18. The activities of the Safeguarding Adults Board are currently wholly funded by Southwark Council.

REASONS FOR URGENCY

19. As part of the protocol between the Safeguarding Adults Board and the Health and Wellbeing Board agreed at the last meeting, the Safeguarding Adults Board is required to present it's annual report to the Health and Wellbeing Board. It is desirable that the annual report is presented at the earliest opportunity.

20. The next meeting of the Health and Wellbeing board is not scheduled to meet until 16 March 2015. Any proposed action arising from the Health and Wellbeing board's consideration will be delayed until then if not taken at this meeting.

REASONS FOR LATENESS

21. The report needed to be signed off by the Safeguarding Adults Board which met on Wednesday 21 January 2015 which was the day of the Health and Wellbeing Board agenda despatch.

BACKGROUND PAPERS

Background Papers	Held At	Contact
No Secrets (2000)	Link below	John Emery
Link: https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care		
Winterbourne Hospital Review and Concordat (2012)	Link below	John Emery
Link: https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response		
Mid-Staffordshire NHS Foundation Trust Inquiry Report (2013)	Link below	John Emery
Link: http://www.midstaffspublicinquiry.com/report		
Care Quality Commission; State of Care 2013-2014	Link below	John Emery
Link: http://www.cqc.org.uk/content/state-care-201314		

APPENDICES

No.	Title
Appendix 1	Southwark Safeguarding Adults Board Annual report 2013-2014

AUDIT TRAIL

Lead Officer	Deborah Klee, Chair of the Safeguarding Adults Board
Report Author	Jon Newton/John Emery
Version	Final Report
Dated	22 January 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		22 January 2015

APPENDIX 1

Southwark Safeguarding Adults Partnership Board

Annual Report 2013-14

Contents

Foreword by the Chair of the Southwark Safeguarding Adults Partnership Board

This is my first annual report as Independent Chair for the Southwark Safeguarding Adults Partnership Board. I joined the Board in January 2014. It has a history of strong partnership working and was impressed with the commitment of all its partners.

The Board has had a busy and productive year and its agenda has grown. It was a year of change. The Care Act was being drafted. The Act will put adult safeguarding boards on a statutory footing. *Making Safeguarding Personal* (LGA and ADASS April 2013) was published, a pivotal report for a change in culture, making safeguarding adults outcome focused rather than process driven. I was privileged to be the project manager of this national study and author of the report. People achieving the outcomes that they want and feeling in control when supported by safeguarding services is an aspiration for the Board and one that we will work towards in 2014.

Sadly the year started with two major national reports highlighting unacceptable care involving the neglect and abuse of vulnerable adults. Both of these inquiries led to recommendations and actions for partnership boards and statutory agencies and the annual report covers them in detail.

The Winterbourne View serious case review report (Dec 2012) followed a Panorama programme that uncovered the systematic abuse of vulnerable adults in a unit for adults with a learning disability. The Safeguarding Adults Board has been working with the local Winterbourne View Steering Group to ensure that lessons have been learned and actions taken to safeguard vulnerable adults in Southwark.

The second report was Francis report on the Mid Staffordshire NHS Foundation Trust inquiry (Feb 2013). The NHS Foundation Trusts represented on the Board provided regular reports to the Board on the implementation of programmes to deliver compassionate care in response to the lessons learnt in Mid Staffordshire.

This year the board has focused on getting assurance that the quality of care provided by social care workers in the person's own home and in care homes is being monitored, that action is taken to prevent abuse by improving the quality of care and that responses to abuse and neglect are proportionate and robust. This was in response to a comparatively high percentage of alleged abuse carried out by social care workers in Southwark in 2012-13. This has now reduced by 4% and is below the national and comparator group median.

In April 2013 local authorities became the statutory supervisory body for care home and hospital Deprivation of Liberty Safeguards (DoLS) authorisations. The Board monitored this change in the management of DoLs applications. In March 2014 the Supreme Court offered additional clarification of DoLS, effectively widening the circumstances under which a person could be seen as being deprived of their liberty. This led to a significant increase in referrals for DoLs from March 2014, a challenge that is likely to continue.

In April 2015 safeguarding adults boards will be on a statutory footing, so our Board needs to develop a strong infrastructure with sound governance arrangements so it works effectively in safeguarding adults in Southwark. As Independent Chair I will ensure that this is achieved.

Deborah Klee
Independent Chair
Southwark Safeguarding Adults Partnership Board

Section 1: Introduction - What is abuse?

In 2000 the Government published ***No Secrets***. This required local authorities to set up a multi-agency framework to ensure not only a coherent policy for the protection of vulnerable adults at risk of abuse, but also a consistent and effective response to circumstances that gave grounds for concern. It gave local authorities a role in coordinating safeguarding activities.

No Secrets defines a vulnerable adult as:

A person aged 18 years or over "Who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation",

And abuse as:

"A violation of an individual's human or civil rights by any other person or persons".

Both definitions are adopted by the *Protecting adults at risk: London multi-agency policy and procedures* from which Southwark derives its protocols and guidance.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable adult is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person.

Abuse can happen anywhere and take place in any context, for example, in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations. Vulnerable adults may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

The Care Act 2014, which will consolidate provisions from various Acts into a single, framework for care and support, is a fundamental reform of the way the law works. With wellbeing at the heart of the Act, it will provide a new framework for adult safeguarding. As the first ever statutory framework for adult safeguarding, it will stipulate local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area.

Section 2: The National Context

Introduction

The year ending March 2014 continued a period of unprecedented change and increased demand for health and social care services. Key documents published in 2013-2014 influenced the safeguarding agenda. They include:

Making Safeguarding Personal (April 2013)[1]

This document is the final report of the Making Safeguarding Personal project and brings together the findings from the four test sites and other councils. Making Safeguarding Personal focuses on establishing a person-centred, outcome focused approach to adult safeguarding. The document sets out the following:

- Practicalities and lessons learned from the projects
- Outcomes for people
- Impact on social work practice
- Cost effectiveness

Southwark will increasingly work on MSP principles from 2014.

The Care Act (May 2014)[2]

This Act consolidates provisions from many Acts into a single, framework for care and support. It is a fundamental reform of the way the law works. It places the wellbeing, needs and goals of people at the centre of the legislation to create care and support which fits around the individual and works for them. It provides a new focus on preventing and reducing needs, and putting people in control of their care and support. For the first time, it brings carers into the law, on a par with those for whom they care.

The Act also provides a new framework for adult safeguarding. It sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area. The role of these Boards will be to develop shared strategies for safeguarding and report to their local communities on their progress.

The Act repeals local authority intervention powers to remove adults from their homes. It does not propose any new intervention powers in their place, but recognises the views of some stakeholders that local authorities should have some ability to intervene positively to protect adults from abuse or neglect.

[1] http://www.adass.org.uk/AdassMedia/stories/making%20safeguarding%20personal.pdf

[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Care Act received Royal Assent in May 2014.

Section 3: Local Context

2013/14 saw the Southwark's Safeguarding Adults Partnership Board membership continue to expand. The Board's governance structure now meets much of the expectation of the forthcoming Care Act. Work continues to ensure this remains the case.

Members of the Board include representatives from the Local Authority, Southwark Clinical Commissioning Group, South London and Maudsley NHS Foundation Trust, Guys & St Thomas NHS Foundation Trust, Kings College Hospital NHS Foundation Trust, Metropolitan Police, London Fire Brigade and Community Action Southwark (representing local community and voluntary organisations).

Locally, the Local Authority and the Clinical Commissioning Group developed their roles in relation to safeguarding adults, particularly as 'chairs' of Board's sub groups.

Generally, there were a number of priority areas that were worked on during 2013-14. They include:

- preparing to meet the demands of the Care Act 2014
- continuing to develop responses to the Winterbourne View Concordat
- enhancing local initiatives to provide compassionate care to hospital patients (a response to the Francis Report).
- ensuring a better approach to safeguarding in residential and nursing care

This report will describe the actions taken locally to meet these challenges.

Section 4: Southwark Multi- Agency Training

Southwark safeguarding multi-agency training

The Safeguarding Adults' Board training and development sub-group comprises a cross section of organisations, contributing to adult care in the borough, to review and create the right training interventions and, to maintain a highly skilled workforce.

In 2013/14 a formal review and benchmarking exercise was undertaken to evaluate the content and delivery of the learning programme. As a result, the Adult Safeguarding Learning Strategy was reviewed, supported by a delivery plan to provide a focused framework for future workforce skills and knowledge.

The learning strategy creates a shared vision and purpose for learning and development. It clearly outlines multi-agency standards and ambitions. Work also commenced on integrating adults' and children's safeguarding learning programmes, where appropriate, as well as providing access to particular Southwark social care professional development support.

Key training performance indicators 2013/14

There has been a significant increase in the number of people completing the online awareness raising programme (level 1). This was primarily due to a specific campaign amongst housing and community services workers. It is open to anyone working with adults at risk in Southwark (https://safeguarding.southwark.gov.uk) and over 5,000 people have completed the e-learning since its launch in 2010.

Overall attendance at safeguarding training sessions has increased by 34% in the past year. Courses are well received with an average 81% positive impact evaluation from participants[3]. There was an increased take-up for Safeguarding Alerter courses from across the partnership and increased demand for domestic violence training.

There is further work to do around non-attendance in certain areas, particular with associates, both in terms of the learning and financial impacts.

Ongoing work

Work continues to support effective learning and development in this area, including:

- Development standards (competency) framework – a universal online tool to support staff to assess "continuing personal development" and practice supervision
- Developing an accreditation framework for all safeguarding training
- Undertake a programme of "impact assessments" to evaluate the effectiveness of learning in practice in the business
- Continuing to increase e-learning programmes – providing greater accessibility to learning opportunities and pre-learning before attending workshops
- Ongoing review and update of training and development requirements in line with wider changes in legislation, including the Care Act

[3] This is based on a post-evaluation survey completed four days after a learning programme.

- Specific targeted programme of interventions to focus on raising the knowledge and awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards

Section 5: Partner Highlights

Southwark Council

Overview of 2013-14

April 2013 saw Adult Social Care reorganise its structure and approach to ensure more focus on personalisation. Support from the Safeguarding Adults Service however, was unaffected and continued to support the newly formed services and teams. The Safeguarding Service continues to support the functions of adult safeguarding across adult social care through policy implementation, practice guidance and quality assurance in adult protection, mental capacity and deprivation of liberty safeguards.

Key Achievements

Following the review of the Southwark Safeguarding Adults Partnership Board (SAPB) sub groups the Head of Organisation Development chairs the Learning and Development Sub-group. The purpose of the sub-group is to offer the SAPB assurances around the purpose and quality of the training offer around safeguarding adults.

The local authority continued to work in partnership with the CCG to meet the requirements of the Winterbourne View Concordat. This work has been supported the Winterbourne View Steering Group and a development of a CCG and LA Strategic Local Area Plan with high level outcomes for people with learning disabilities. Progress is monitored against this action plan at the steering group.

Southwark Safeguarding Partnership together with My Home Life and provider partners produced a quality strategy covering quality assurance, integrated working, safeguarding, workforce development and working together in the future.

A multi-agency thresholds document was produced by the Safeguarding Team. This followed an event in December 2013 aimed at developing a joint threshold with a neighbouring Borough with the aim of supporting mutual local partners. Based on work of other London Boroughs, a Threshold agreement was adopted in March 2014 (see Appendix One).

Southwark Clinical Commissioning Group

Overview of 2013-14

Southwark Clinical Commissioning Group (CCG) came into being on 1 April 2013. The CCG has continued to work in close partnership with the Local Authority (LA) with regards safeguarding adults.

The CCG's has a Safeguarding Executive Committee with membership from all key partners. The Clinical Lead for Safeguarding is a member of the Executive Committee. The Safeguarding Executive Committee reports to the Southwark Clinical Commissioning Committee via the Integrated Governance & Performance Committee and directly to NHS England, via the Chief Nurse.

As commissioners of heath care provision Southwark CCG are committed to ensuring that all contracted services have the appropriate systems in place to safeguard and are compliant with the safeguarding alerting processes in Southwark.

Key Achievements

Following the review of the Southwark Safeguarding Adults Partnership Board (SAPB) sub groups the CCG Head of Continuing Care & Safeguarding chairs the Quality and Performance Sub-group. The purpose of the sub-group will be to offer the SAPB assurances around the quality and of the local safeguarding adult responses and though this to improve the effectiveness of the Board.

The CCG continued to work in partnership with the LA to meet the requirements of the Winterbourne View Concordat. This work has been supported the Winterbourne View Steering Group and a development of a CCG and LA Strategic Local Area Plan with high level outcomes for people with learning disabilities. Progress is monitored against this action plan at the steering group.

The CCG monitors and reports to NHS England on all health care commissioned hospital placements and client placed inappropriately in hospital (assessment and treatment) to ensure that these clients are transferred to community based transport as soon as possible. Working in partnership with the LA and Mental Health Services, a number of discharges to community based care for clients, originally identified as being in hospital for a significant period of time, have been achieved. These include transfers to supported living arrangements and family homes.

In order to raise awareness around the Mental Capacity Act (MCA) and the roles and responsibilities of health practitioners the CCG have provided training within the protected learning time programme. The CCG have also secured further funding from NHSE to support a specific training programme on MCA for General Practices 2014/15.

Section 6: Priority Areas for 2013-14

Safeguarding Adults Partnership Board Response: Care Act 2014

As noted earlier the Care Act became law in April 2014. However, in response to the expected changes the Act will bring Southwark Safeguarding Adults Partnership has, following the appointment of Deborah Klee as the new independent chair reviewed its membership and created a simplified sub-group structure. The membership now includes representatives from Southwark Housing, Healthwatch, GP's, and Community Action Southwark in addition to representatives from Adult Social Care, NHS and the Police. The new sub-groups are: Prevention and Awareness Raising chaired by the local authority Head of Organisational Development, and Quality and Performance chaired by the CCG Head of Continuing Care and Safeguarding. The HR and Recruitment sub-group (joint with Southwark Safeguarding Children's Board) will continue as previously. On the basis of guidance provided thus far by the Department of Health these sub-groups, which concentrate on quality, prevention and safer recruitment, will provide a solid basis on which to comply with the demands of the Act and, more importantly, improve outcomes for adults at risk of abuse in Southwark.

Information leaflets published by the Department of Health regarding safeguarding adults under the Care Act are clear that safeguarding enquiries should not be a substitute for commissioning action via contract compliance nor should they be a substitute for management action on the part of a provider. In response to this guidance in December 2013 Southwark Safeguarding Adults Partnership in conjunction with Lambeth Safeguarding Partnership held a joint seminar to develop common thresholds for initiating formal safeguarding enquiries. Whilst it was not possible to develop a common agreement between the two boroughs Southwark safeguarding Adults Partnership has gone on to develop a thresholds document (see Appendix 1) that offers guidance to operational staff carrying out safeguarding enquiries.

Care Act guidance states that each Safeguarding Adults Board must produce a strategic 3 year plan and associated work plan. Guidance to the Act also states that the Board should seek to integrate its work with other relevant Boards such as the Southwark Safeguarding Children's Board and Safer Southwark Partnership. The Southwark Safeguarding Adults Board will seek to complete both of these areas during 2014-2015.

The Care Act is explicit in stating that all safeguarding enquiries should seek to achieve the outcome or outcomes stipulated by the adult at risk, or their representative in situations where the adult at risk lacks capacity to make an informed decision regarding the alleged allegation of abuse. To achieve this end Southwark Safeguarding Adults Partnership will sign up to the national 'Making Safeguarding Personal' initiative in autumn 2014 with a view to achieving 'Gold' standard over three years. During year one the Partnership will aim to achieve 'Bronze' standard by demonstrating that together with the adult at risk we identify their preferred outcomes from the safeguarding enquiry, that we involve the person throughout the enquiry and that we can demonstrate that we have done these things and achieved their preferred outcomes at the end of the process.

Response to the Winterbourne Hospital Review & Concordat

A multi-agency steering group undertook the response to the DH Winterbourne View Hospital Review and its associated Concordat. The group, chaired by the Director of Adult Social Care, initiated a programme of work to meet the demands of the Concordat. Beginning initially with reviews of all service users placed in hospital or assessment and treatment settings and then moving towards the ultimate aim of development of greater capacity locally to provide services that meet the needs of both children and adults with learning disabilities that challenge services. The foundations for this ultimate aim will be laid between April 2013 and June 2014.

The table in Appendix Two lists key achievements thus far and illustrates how these initiatives correspond with safeguarding principles:

Significant progress has been made during the last year on the actions set out in the 2013 Winterbourne View Steering Group Action Plan.

In July 2013 Southwark took part in a national stocktake which was designed to enable local areas to assess their progress against commitments in the Winterbourne View Concordat, share good practice and identify development needs. The report, published jointly by the Local Government Association and NHS England, was an analysis that covered all 152 Health and Wellbeing Board areas.

Feedback from the Joint Improvement Programme Team stated that Southwark's submission provided a comprehensive picture about some excellent progress and pointers to the priorities we had identified for further work.

A Strategic Local Area Plan was completed and submitted to the Winterbourne View JIP by the deadline required by *Transforming Care* (April 2014).

Local Initiatives to Provide Compassionate Care to Hospital Patients

The Francis Report (2013)[4] into the care at Mid Staffs Hospital between 2005 and 2008 concluded that the large number of deaths were due to the concentration on targets and the achievement of foundation trust status at the expense of maintaining compassionate values in the delivery of care.

Guy's and St Thomas' NHS Foundation Trust has continued to develop its 'Barbara's Story' training package which now consists of six episodes and is now available in shortened form on You Tube for the general public to see. The package has been evaluated for effectiveness by London South Bank University and concluded that the first episode of Barbara's Story made a lasting impression on staff, prompting them to reflect on their own practice and that of others, leading to resolutions for improvements. It was also reported that there was strong evidence that Barbara's Story raised awareness of dementia and, more generally, patients' experience and their need for help.

Both King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust have strengthened their safeguarding adults teams during 2013 – 2014. King's have appointed a Head of Safeguarding for the Trust and are looking to appoint to a number of safeguarding posts across their sites whilst SLAM have appointed a Director of Social Care and are looking to appoint an Adult Safeguarding Lead. Both trusts are looking for these posts to improve responses to adult safeguarding allegations and also to embed a compassionate approach to care in both organisations.

[4] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Quality in Residential and Nursing Care

The CQC in its State of Care 2013/2014[5] report stated there was a slight improvement in the quality of adult social care overall. However, performance on safety and safeguarding was slightly weaker than 2012/2013. In particular, the CQC found that people living in nursing homes continued to receive poorer care than those living in residential homes with no nursing provision whilst care homes with a registered manager in place delivered better quality care than those without a manager.

Against CQC performance standards homes with a manager delivered 10-15% higher performance than those without. In Southwark the prevalence of alleged abuse of adults at risk who live in care homes in 2013/2014 was 22% of the total number of alerts whilst in comparator boroughs it was 22.5% and 36% nationally. (See Appendix 2 Chart 3.5)

Southwark Safeguarding Partnership together with My Home Life and provider partners has produced a quality strategy covering the following domains:

- Quality Assurance
- Integrated Working
- Safeguarding
- Workforce Development
- Working Together in the Future

The strategy can be found here:
http://moderngov.southwark.gov.uk/mgIssueHistoryHome.aspx?IId=22385&optionId=0

The impact of the strategy will be evaluated in November 2014, and the findings will be used to produce a refreshed action plan.

In addition to working with providers proactively to improve services the Southwark Safeguarding Partnership still responds robustly to instances of poor care and neglect. For example, one care home in the borough has been under embargo since February 2014 as a result of issues with care planning, multiple medication errors, staffing and management. Staff from Adult Social Care, Southwark Commissioning and NHS partners have been working with the provider to implement a recovery and improvement plan.

[5] State of Care 2013/14

Mental Capacity Act/DoLS Activity 2013/2014

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA/DoLS) came into effect on 1st April 2009.

It amended a breach of the European Convention on Human Rights and provided for the lawful deprivation of liberty of those people who lack the capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm.

Until April 2013, CCG's and local authorities (designated as 'supervisory bodies' under the legislation) had the statutory responsibility for operating and overseeing the MCA/DoLS whilst hospitals and care homes ('managing authorities') have responsibility for applying to the relevant CCG or local authority for a Deprivation of Liberty authorisation. After April 2013, local authorities became the sole statutory supervisory body for both care home and hospital DoLS authorisations and in Southwark, the Safeguarding Adults Team manages this responsibility. In 2013-2014 the team processed a total of 45 DoLS authorisations of which 41 were authorised and 4 refused. (See Appendix Three for further details)

The legislation includes a statutory requirement for all care homes and hospitals as well as local authorities to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

On March 19th 2014, the Supreme Court handed down its judgement in the case of *P v Cheshire West and Chester Council* and another' and *P and Q v Surrey County Council*. In this judgement, the Court ruled that a deprivation of liberty takes place when the person is under continuous supervision and control, and is not free to leave, and the person lacks capacity to consent to these arrangements.

The Court held that factors that are not relevant to determining a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The Court also said that the relative normality of a placement given the person's needs was not relevant. The Court also held that a deprivation of liberty can occur in domestic settings where the state is responsible for imposing such arrangements. This includes supported living arrangements and, on occasion, the person's own home. Where there is likely to be a deprivation of liberty in such placements these must be authorised by the Court of Protection.

The effect of this judgement will be to create a great demand for DoLS assessments. As an indication of this increased demand, by the end of March 2014 the Safeguarding Adults Team had received requests for 41 assessments for DoLS authorisations compared with 45 requests for the whole of 2013-14.

Section 7: Safeguarding Statistical Analysis

Safeguarding activity continued to increase in general through 2013-14 and there were particular increases higher than the previous year. Appendix Three contains Southwark's statistics in comparison to our (nationally recognised) comparator councils.

Highlights

- 665 safeguarding adults referrals progressed to a safeguarding enquiry
  This represents a 24.7% increase in enquiries over 2012/2013.
  This is 40% higher than the median of 475 in Southwark's London comparator group. (See Appendix Four, Chart 1)[6].

- Referrals divided equally between younger adults (18-64) & older adults (65+) - 50%.
  Comparator group figures are 43.5% (18-64) and 57.5% (65+)
  Nationally figures are 37% (18-64) and 63% (65+)
  (Appendix Four, Chart 1.1)

- 54% of alleged abuse of older adults is against the older elderly (75+).
  This is recognised as a factor in national surveys (e.g. Action on Elder Abuse 2007). Those aged 75+ are more likely to be in poor health, dependent on others and are more likely to live alone or be isolated all of which are factors that increase the likelihood of abuse.

- Nationally the most prevalent form of abuse reported was neglect and acts of omission at 30% of all reports, followed by physical abuse with 27%. Whilst in Southwark 22% of allegations were concerning neglect, whilst 27% of allegations were regarding financial abuse and 25% involved physical abuse.

- The most common location for allegations of abuse was the adult at risk's own home, the respective figures being nationally 42%, in Southwark 46% and the local comparator group median 51%. Care homes were the next most common location for allegations of abuse with the national figure being 36%, the local comparator group median 22% and Southwark 23%.

- The most common source of risk (alleged perpetrator) was most commonly someone known to the alleged victim but not in a social care capacity. The figures were local comparator median 52.5%, Southwark 43%, nationally 49%. Social care employees were the source of risk in 36% of allegations nationally. The local comparator median was 30% and in Southwark the figure was 28% compared with 32% in 2012/2013.

[6] Health and Social Care Information Centre: Safeguarding Adults Return Annual Report England 2013-14

Section 8: Priorities for the next 12 months

- Develop Three Year Strategy and annual work plan for the Safeguarding Adults Board

- Establish subgroups with realistic work plans to deliver the work required.

- Ensure partners and providers are aware of the widening of the Deprivation of Liberty Safeguards Criteria and create resources to deal with the increased workload including training more qualified best interest assessors

- Ensure all partners and providers are aware of their wider responsibilities under the Care Act 2005 (e.g. best interest decisions) through provision of appropriate training in all sectors, such that the Board is in a strong position to take on its statutory role in 2015.

- Develop a protocol and forum for joint work with the Southwark Safeguarding Children's Board, the Safer Southwark Partnership and the Health and Well-being Board

- Carry out a qualitative and process audit of safeguarding adults practice

Appendix One: Southwark Safeguarding Adults Threshold Decisions

Threshold decisions are made in relation to whether or not an alert concerning an adult, who meets the *No Secrets* definition of 'vulnerable', is allegedly subject to abuse by a third party and is in need of consideration by the Protecting Adults at Risk: London Multi Agency Policy & Procedure to safeguard adults from abuse http://southwarkadults.proceduresonline.com/pdfs/protect_adults_at_risk.pdf

Threshold decisions are made on the basis of a combination of the factors the most important of which is **significant harm** to the individual concerned. The power dynamic between people in a harmful situation also needs to be assessed as a contributor to significant harm as it may render them powerlessness to stop or prevent on-going abuse (i.e. being unable to protect oneself).

The following two tables encompass 1) a description of areas for consideration in making threshold decisions, together with 2) a range of scenarios which may reflect either poor practice or abuse, dependent upon the facts of the particular case/incident to be considered.

This document is only a guide to decision-making and should not replace professional judgment. Any incident that poses a risk of abuse or has resulted in abuse of a vulnerable adult should be reported as a safeguarding incident. However, when conducting safeguarding enquiries /investigations it is imperative to establish what outcomes the adult at risk wants from such an investigation and at the end of the investigation to check that these have been achieved.

Acknowledgement - this information has been adapted from work by Kate Spreadbury undertaken for the South West Joint Improvement Partnership Adult Safeguarding Programme

Acknowledgement – this information has been adapted from *Collins M. Thresholds in Adult Protection- the Journal of Adult Protection Volume 12 Issue 1, February 2010*

With thanks to the London Borough of Camden Safeguarding Adults/DoLS Service

Areas for consideration in decision making

Consideration	Possible Information Source	Decide
Nature of alleged abuse	Persons own account Witness account Reports to police, CQC Alerter account	Does this alleged abuse meet the definitions of abuse in No Secrets? **If not:** Consider whether it is possible to effectively signpost to another source of support **If yes:** Did the alleged abuse lead to actual harm? Is there a strong possibility it will lead to future harm? Is there significant harm?
Power issues		
The person needs the assistance of others to attend to their basic needs	Persons own account Alerter account Agency records	Is the person experiencing difficulties in accessing protection or ensuring their own human or civil rights are met? Is there potential for the risk to increase because the alleged perpetrator is responsible for the persons care or well being?

Consideration	Possible Information Source	Decide
The person lacks the mental capacity to assess risk or decide on protective courses of action	Mental capacity assessment	Is the person's vulnerability and likelihood of significant harm increased as a result of them being unable to assess risk or decide on a course of action increases?
The person is under duress	Persons own account (interview separately) Accounts of others, e.g. alerter, other agencies Existing records	Are there others in control of the person's life, either by controlling access to services, delivering care, living at the same address, who are exerting duress?
The person is isolated	Persons own account Accounts of others, e.g. alerter, other agencies Existing records	Is the isolation making it hard for the person to self protect or get assistance? Do they have family or friends who will speak up on their behalf if needed? Is there the likelihood of the person being targeted by people who want to exploit them?
The person has experienced previous abuse	Persons own account Accounts of others, e.g. alerter, other agencies Police records Other records	Does the person's internalised feelings of worthlessness or low expectations of others people (possibly as a result of experience of either their own abuse or the abuse of others) affect their perception of the situation? Has the person experienced domestic abuse? Are they still in an abusive relationship? Does the person feel powerless and unable to change their situation? If a previously abusive partner or family member is now dependent on the person they have abused (domestic abuse or child abuse) could there be a possibility of retribution, or maintenance of previous power dynamics?

Consideration	Possible Information Source	Decide
The person, or person allegedly harming them, is addicted to substances or gambling	Persons own account Accounts of others, e.g. alerter, other agencies Existing records	Is the addiction affecting the alleged abusive situation? Is it likely to prevent action being taken to resolve the safeguarding situation? Is the person dependent on the alleged abuser to sustain their addiction? Is the alleged abuser focused on using the person to maintain their habits and not on the person's well being? Is the influence of addiction leading to risky behaviour, dis-inhibition and poor judgments?
Impact of the alleged abuse on the person		
Physical impact	Documented injuries Accounts/reports from medical practitioners Persons own account Accounts of others	Safeguarding adults procedures are designed to protect people who are unable to protect themselves without assistance, therefore any physical injury should lead to consideration of use of SA procedures If SA Procedures deemed inappropriate but concerns remain consider effective signposting to appropriate agency/source of support.
Emotional impact	Persons own account Observations of others	What impact is the emotional distress having on the persons' quality of life? Is the impact immediately obvious? Is there potential that it will emerge at a later date? Does the person appear to be having difficulty remembering the cause of the incident or event, but is showing general anxiety or fearfulness? Is the person having difficulty articulating their feelings?

Consideration	Possible Information Source	Decide
Other risks		
This has occurred in the past	Existing records Persons own account Accounts of others	Is there a pattern of incidents suggesting this is not a "one off "event and that there is potential that the people, or others, are still at risk.
Likelihood that the risk will occur again	Risk assessment using all the above	Does the allegedly abusive person still have contact with the person? Is the person still living in circumstances that mean other incidents may occur if risk factors are not explored?
Others, including children, are at risk of further harm	Existing records Persons own account Accounts of others	Is there a need to make a referral to safeguarding children's services? Should information be passed to MAPPA and MARAC? Should Information be passed to the Hate Crime/Safety Intervention Panel?
Course of action		
What is the persons preferred course of action?	Persons own account	Has the person concerned indicated that they want no further action taken?
	Persons expressed desired outcome?	Is there any early information on what their preferred course of action would be?

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person does not have within their care plan/service delivery plan/treatment a section that addresses need such as • Management of behaviour to protect self or others • Need for liquid diet because of swallowing difficulty • Cot sides to prevent falls and injuries but no harm occurs	Possible abuse A failure to specify in a person's plan how a significant need must be met. Inappropriate action or inaction results in harm such as injury, choking, etc. * **If this is also a common failure in all care plans in the Care Home/Hospital/Care Agency then the threshold will be passed for whole service/ institutional abuse investigation*
Poor Practice: Person's needs are specified in treatment or care plan but plan is not followed. Needs are not met as specified but no harm occurs	Possible abuse: A failure to address a need specified in the persons plan and which results in harm. This is especially serious if it is a recurring event or is happening to more than one adult. **If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*

Poor Practice: Person does not receive necessary help to have a drink/meal on one occasion	Possible abuse: A recurring event or one that is happening to more than one adult. Harm occasion: weight loss, hunger, thirst, constipation, dehydration, malnutrition, tissue viability, medication problems. **If this is a common occurrence in this setting or there are no policies/protocols in place regarding assistance with eating or drinking, or prescribed medication, the threshold will be passed for whole service/institutional abuse investigation*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person does not receive the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed incontinence pads on one occasion	Possible abuse: A recurring event or one that is happening to more than one adult. Harm: pain, constipation, loss of dignity and self-confidence, skin problems. *If this is a common occurrence in this setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure sore risks, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Medication is not administered as set out in the care plan to a person as prescribed or is not given to meet the persons current needs	Possible abuse: A recurring event or one that is happening to more than one person. Inappropriate use of medication that is not consistent with the person's needs. Harm: pain is not controlled, physical or mental health condition deteriorates/person is kept sleepy/unaware; side effects noticeable; put at risk. *Continual medication errors, even if they result in no significant harm are a strong indicator of poor systems, staff compliance or training. Urgent remedial action, either via safeguarding adults or quality improvement strategies must be undertaken.*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person who is known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management, but no discernible harm has arisen yet	Possible abuse: Person has not been formally assessed and/or advice not sought with respect to pressure area management; or plan not followed. Harm: avoidable significant tissue damage. *If this is a common occurrence in the setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure ulcer risks, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice Person does not receive recommended assistance to maintain mobility on one occasion	Possible abuse A recurring event or one that is happening to more than one person resulting in reduced mobility. Harm: loss of mobility, confidence and independence. *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Appropriate moving and handling procedures are not followed or staff are not trained and competent to use the required equipment but the person does not experience harm	Possible abuse: Person is injured or the non-use of moving and handling procedures makes this very likely to happen. Harm: injuries such as falls and fractures, skin damage, lack of dignity. If *this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Person has been formally assessed under the Mental Capacity Actand lacks decision specific capacity e.g. from traffic. Steps taken to protect them are not `least restrictive`. Steps need to be reviewed and a referral for Deprivation of Liberty Safeguards may be required Monitor via reviews	Possible abuse Restraint/possible deprivation of liberty is occurring (e.g. cot sides, locked doors, complete control over person's daily life, medication) and the person has not been the subject of a best interests meeting or DoLS assessment Follow up required via Safeguarding Adults/DoLS team. Harm: loss and freedom of movement, emotional distress.

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person is spoken to once in a rude insulting and belittling manner, or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed.	Possible abuse: A recurring event or one that is happening to more than one person. Insults contain discriminatory e.g. racist, homophobic abuse. Harm: distress, demoralisation, other abuses may be occurring as rights and dignity are not respected. If *this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Person is discharged from hospital without adequate discharge planning, procedures not followed but no harm occurs.	Possible abuse Person is discharged with significantly inadequate discharged planning, procedures are not followed and experiences significant harm as a consequence. Harm: care not provided resulting in increased risks and/or deterioration in health and confidence; avoidable readmission. *If the incident shows poor discharge planning throughout a hospital trust or on a specific ward then urgent remedial action, either via a whole service/institutional abuse investigation, or quality improvement strategies, must be considered.*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs	Possible abuse Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk Harm: missed medication and meals, if they are put at risk of significant harm including neglect *If this practice is evident throughout the care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation.*
Poor Practice Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care or therapy does not on one occasion receive required/requested medical attention in a timely fashion	Possible abuse Adult at risk is provided with an evidently inferior medical service or no service at all, and this is likely to be because of their disability or age or because of neglect on the part of the provider Harm: pain, distress and deterioration of health *If there is evidence that others have also been affected, or that there is a systemic problem within the provider service than a whole service/institutional abuse investigation must be initiated*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor practice by housing providers: Person is known to be living in housing that places them at risk from predatory neighbours or others in the community and housing department/association is slow to respond to their application for urgent re-housing - but no harm occurs	Possible abuse Housing provider fails to respond within a defined and appropriate timescale to address the identified risk and harm occurs. Harm: financial, physical, emotional abuse
Poor practice by housing providers: A resident in a warden complex reports that s/he finds the warden overbearing and intrusive	Possible abuse At least one resident is intimidated and feels bullied by the warden and they are too frightened to talk about why. Harm: emotional/psychological distress
Poor practice by housing providers: Adults at risk need housing repairs arranged by their landlord. There is undue delay but repairs are completed eventually and no harm has occurred.	Possible abuse Landlord persists in not arranging repairs that are urgently required to maintain the safety of the person's environment. Harm: physical and/or emotional e.g. from dangerous wiring, damp, or lack of security
Incident between **two adults living in a care setting** One adult` taps` or `slaps` another adult but has left no mark or bruise and the `victim` is not intimidated and significant harm has not occurred. **Or** One adult shouts at another in a threatening manner and victim is not intimidated and significant harm has not occurred.	Possible abuse: Predictable and preventable (by staff) incident between two adults where bruising, abrasions or other injuries have been sustained and/or emotional distress caused. *A significant level of violent incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment, or poor supervision and management of the service. In such situations consideration should be given to whole service/institutional abuse Investigation*

Appendix Two: Winterbourne View Strategic Area Plan

Challenging Behaviour Pathway	Principle
During 2014, the council has worked with partners in SLaM and GSTT to pilot an **Enhanced Intervention Support Service** which offers: • An intensive intervention service and additional support during times of crisis for service users and their families or care providers; • Enhanced clinical service planning and step-down short-term intervention for people with complex needs and challenging behaviour returning back to borough from out of area; • Preventative work with other partners and providers (internal and external) who support people with complex needs in order to strengthen local services through training in development of capable environments, positive behavior support, consultation and quality audit; • Opportunities for the reduction in expenditure on high cost specialist residential assessment and treatment services. • A training programme for the social work team to further develop support for people with complex / challenging behaviour. Outcomes for the 6 service users included in the pilot have been positive, supporting: • Step down from assessment and treatment (1 person) • Return from out of area residential care (2 people) • Diversion from out of area residential placement (2 people). The pilot has also achieved financial savings and a business case for a permanent team is being developed. The extension of the pilot to include young people is also being explored. This initiative has been identified by the National Winterbourne View Joint Improvement Board as being an area of good practice.	Partnership & Prevention
Better support for struggling families	
An Enhanced Family Linkage Scheme has been commissioned to promote and facilitate peer support networks for those families who care for people whose behaviour challenges services. This initiative will be co-ordinated by the Challenging Behaviour Foundation and sit within Southwark Carers.	Prevention / Partnership Empowerment
Autism Pathway	
• The Joint Strategic Needs Assessment has been extended to cover both learning disabilities and autism and is an all age needs assessment. This is being developed by Adults' and Children's Services, the CCG and Public Health and will inform strategies and service provision. • Options for the development of an Adult Autism MDT are in	Partnership

progress.	
Review and move people on from hospital settings	
All adults and children as defined in *Transforming Care* were involved in their person centred reviews within the timescales set out by the Winterbourne View Joint Improvement Board. Their progress towards the least restrictive, community setting which is appropriate to their needs continues to be monitored by the Winterbourne View Steering Group. New community based, rehabilitation and step down services are being developed locally to support those people who want to move back to Southwark. This forms part of the strategic care pathway and progression approach to achieving optimum independence and choice. Providers have been encouraged to share ideas, work in partnership and develop innovative, personalised services.	Accountability/ Proportionality/ Partnership
Quality Improvement and Quality Assurance	
A multi agency Quality Improvement and Safeguarding Group meets regularly and has enhanced links with local providers. During 2014/15 work will continue to encourage providers to develop the Driving Up Quality standards across their services. This quality assurance framework will support service user and family involvement in the evaluation of services.	Partnership / Prevention / Accountability / Empowerment

Appendix Three: Deprivation of Liberty Safeguards Statistics

DOLS Summary Sheet		Count	%
Authorisation granted/not granted			
1	Granted	41	91%
0	Not Granted	4	9%
Total		*45*	*100%*
Age at case start			
18-64		15	33%
65 and over		30	67%
Total		*45*	*100%*
Gender			
1	Male	22	49%
2	Female	23	51%
Total		*45*	*100%*
Ethnic Origin			
1	White	29	64%
2	Mixed/Multiple ethnic groups	2	4%
3	Asian/Asian British	0	0%
4	Black/Black British	8	18%
5	Other Ethnic origin	1	2%
6	Not stated	5	11%
7	Undeclared/Not Known	0	0%
Total		*45*	*100%*

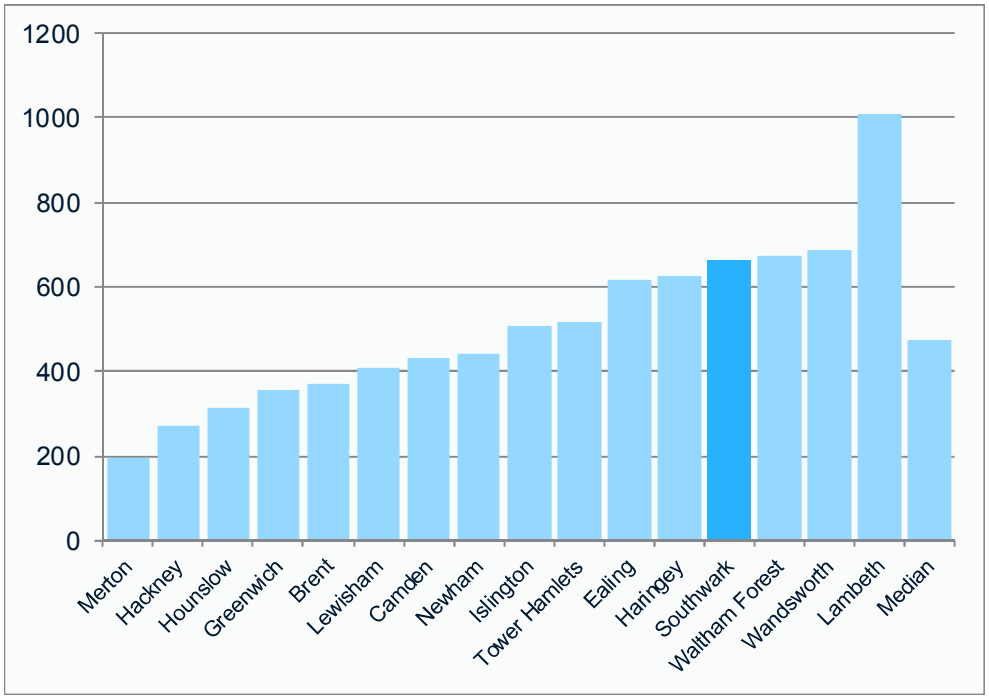
Appendix Four: Statistics 2013 - 2014

Southwark's Safeguarding Adults Return 2013-14, compared to our comparator councils

The 15 councils included in the tables below, in addition to Southwark, are those councils which the Chartered Institute of Public Finance (CIPFA) has identified as being demographically and statistically similar to Southwark.

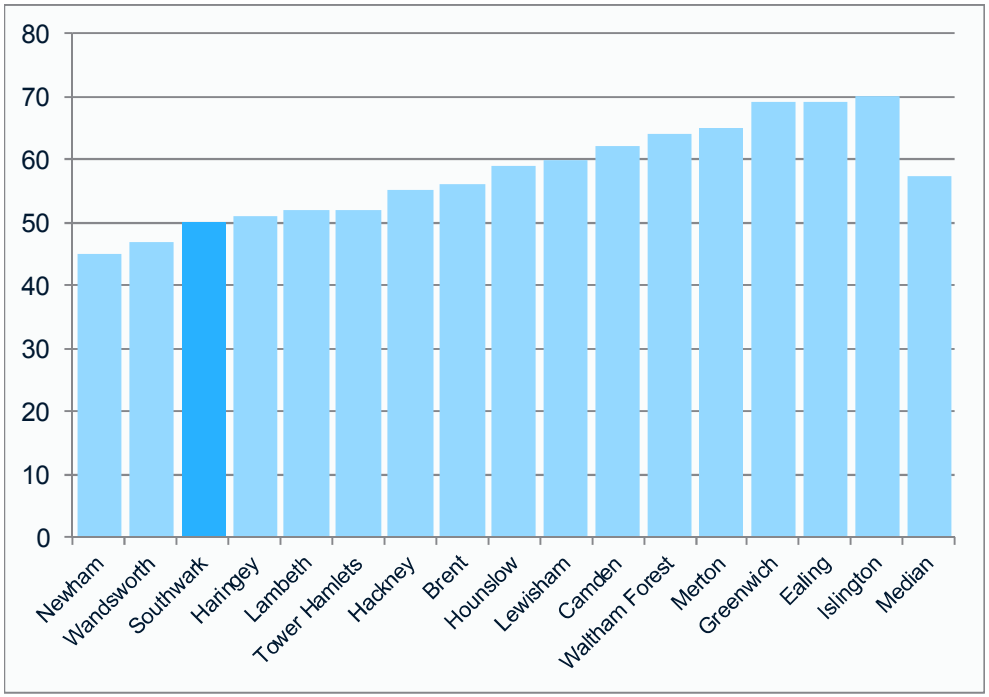
1. Individuals with an open referral

Council (in rank order)	No
Merton	195
Hackney	270
Hounslow	315
Greenwich	355
Brent	370
Lewisham	410
Camden	435
Newham	440
Islington	510
Tower Hamlets	520
Ealing	615
Haringey	625
Southwark	665
Waltham Forest	675
Wandsworth	690
Lambeth	1010
Median	475



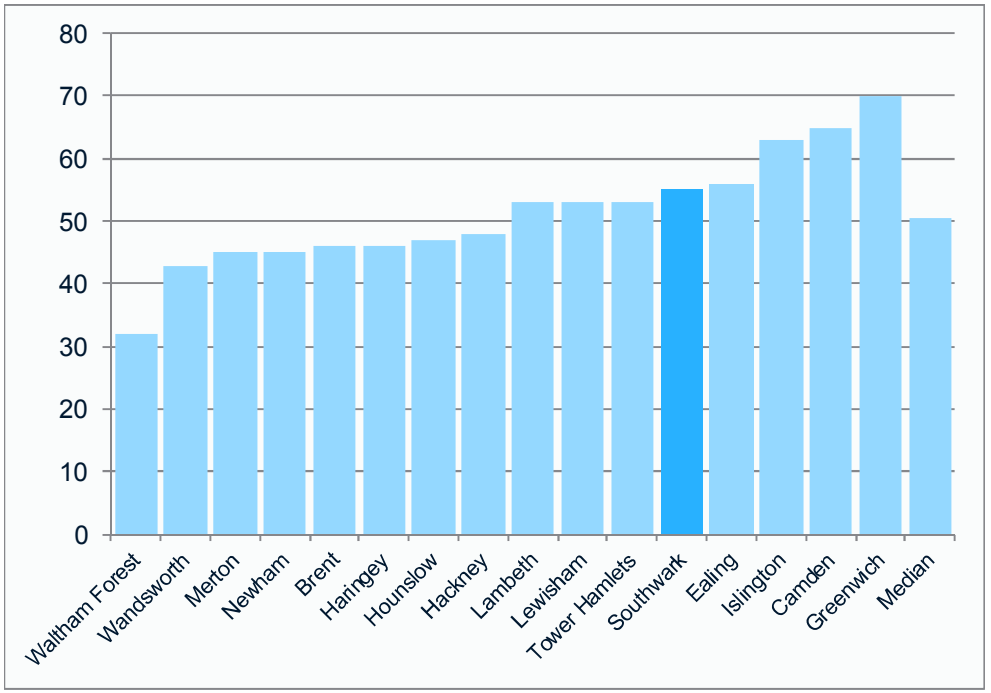
1.1 Of the open referrals, the percentage which were for people aged 65 and over

Council (in rank order)	No
Newham	45
Wandsworth	47
Southwark	50
Haringey	51
Lambeth	52
Tower Hamlets	52
Hackney	55
Brent	56
Hounslow	59
Lewisham	60
Camden	62
Waltham Forest	64
Merton	65
Greenwich	69
Ealing	69
Islington	70
Median	57.5



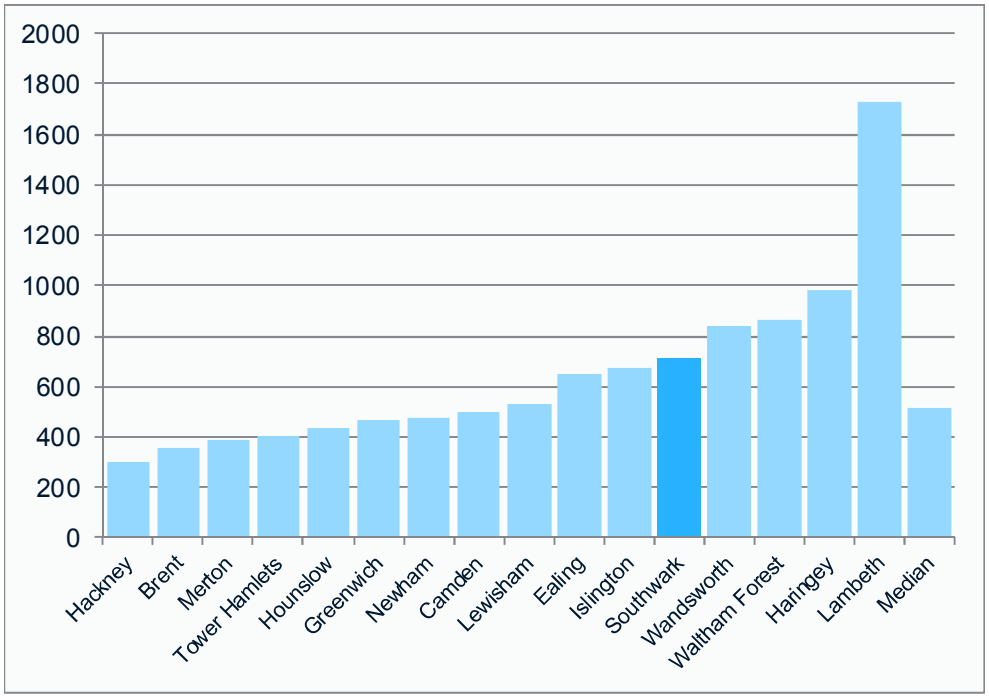
1.2 Of the open referrals, the percentage which were for people with a physical disability

Council (in rank order)	No
Waltham Forest	32
Wandsworth	43
Merton	45
Newham	45
Brent	46
Haringey	46
Hounslow	47
Hackney	48
Lambeth	53
Lewisham	53
Tower Hamlets	53
Southwark	55
Ealing	56
Islington	63
Camden	65
Greenwich	70
Median	50.5



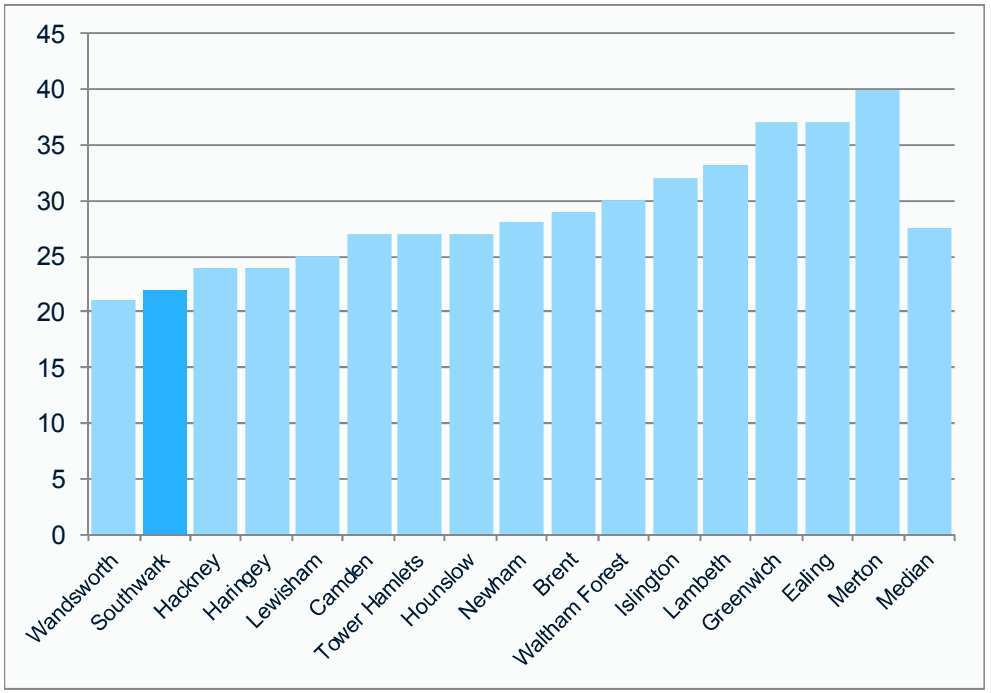
2. Total number of concluded referrals where the risk was identified

Council (in rank order)	No
Hackney	300
Brent	360
Merton	385
Tower Hamlets	400
Hounslow	435
Greenwich	465
Newham	475
Camden	500
Lewisham	530
Ealing	650
Islington	675
Southwark	710
Wandsworth	840
Waltham Forest	860
Haringey	980
Lambeth	1725
Median	515



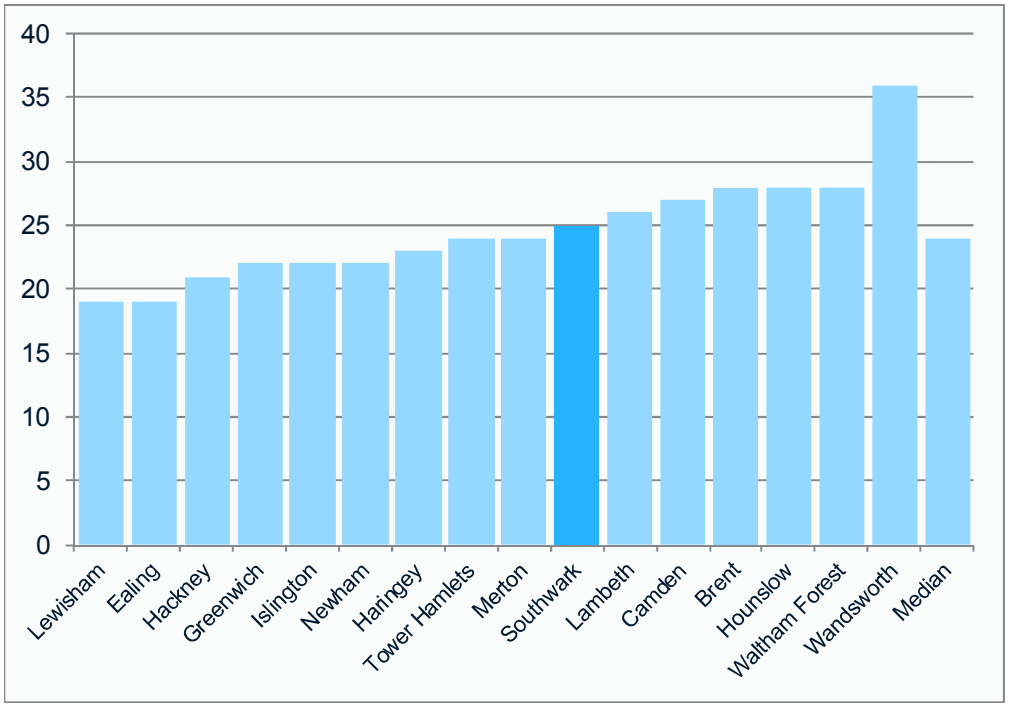
2.1 Of the concluded referrals, the percentage where the risk was identified as neglect

Council (in rank order)	No
Wandsworth	21
Southwark	22
Hackney	24
Haringey	24
Lewisham	25
Camden	27
Tower Hamlets	27
Hounslow	27
Newham	28
Brent	29
Waltham Forest	30
Islington	32
Lambeth	33
Greenwich	37
Ealing	37
Merton	40
Median	27.5



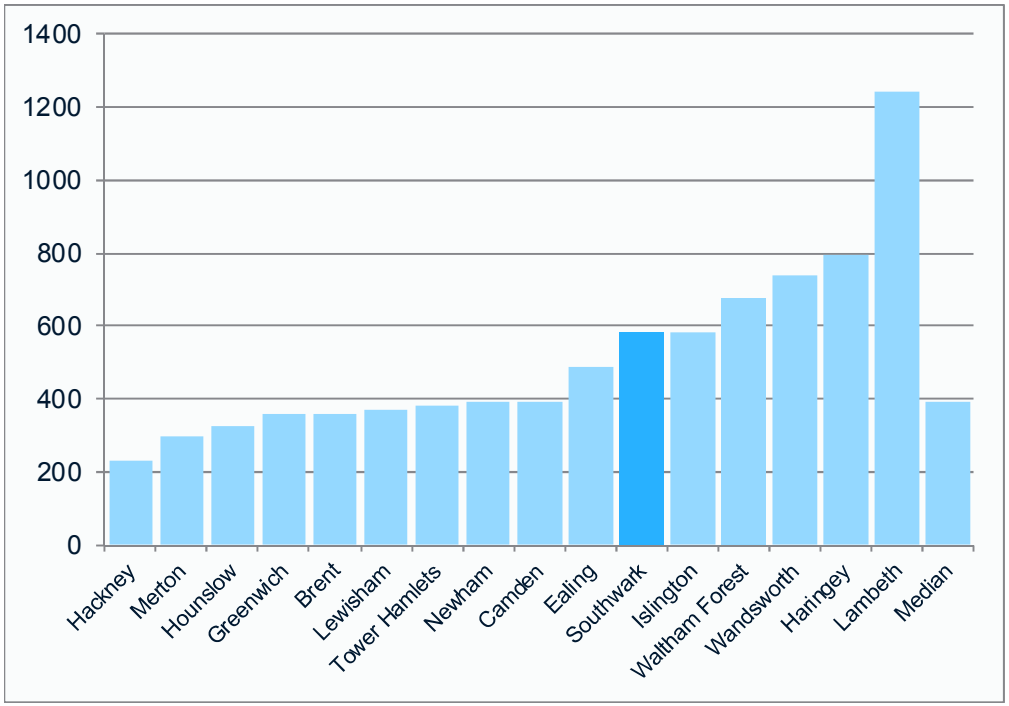
2.2 Of the concluded referrals, the percentage where the risk was identified as physical

Council (in rank order)	No
Lewisham	19
Ealing	19
Hackney	21
Greenwich	22
Islington	22
Newham	22
Haringey	23
Tower Hamlets	24
Merton	24
Southwark	25
Lambeth	26
Camden	27
Brent	28
Hounslow	28
Waltham Forest	28
Wandsworth	36
Median	24



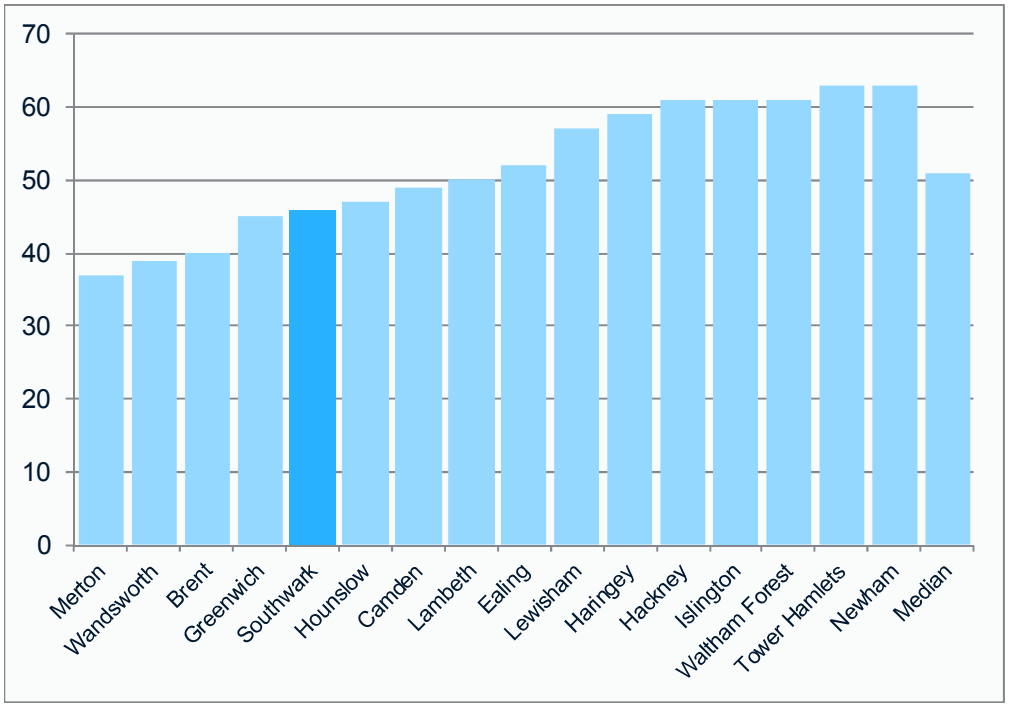
3. Total number of concluded referrals where location was identified

Council (in rank order)	No
Hackney	230
Merton	300
Hounslow	325
Greenwich	360
Brent	360
Lewisham	370
Tower Hamlets	380
Newham	390
Camden	395
Ealing	490
Southwark	580
Islington	585
Waltham Forest	675
Wandsworth	740
Haringey	795
Lambeth	1240
Median	392.5



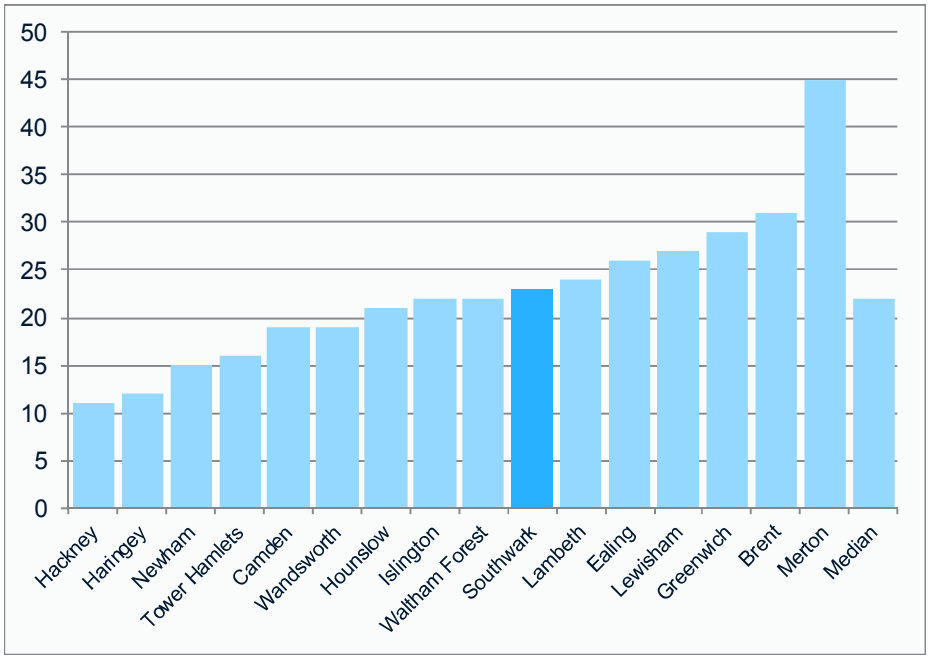
3.1 Of the concluded referrals with location identified, the percentage where the abuse took place in the victims own home

Council (in rank order)	No
Merton	37
Wandsworth	39
Brent	40
Greenwich	45
Southwark	46
Hounslow	47
Camden	49
Lambeth	50
Ealing	52
Lewisham	57
Haringey	59
Hackney	61
Islington	61
Waltham Forest	61
Tower Hamlets	63
Newham	63
Median	51



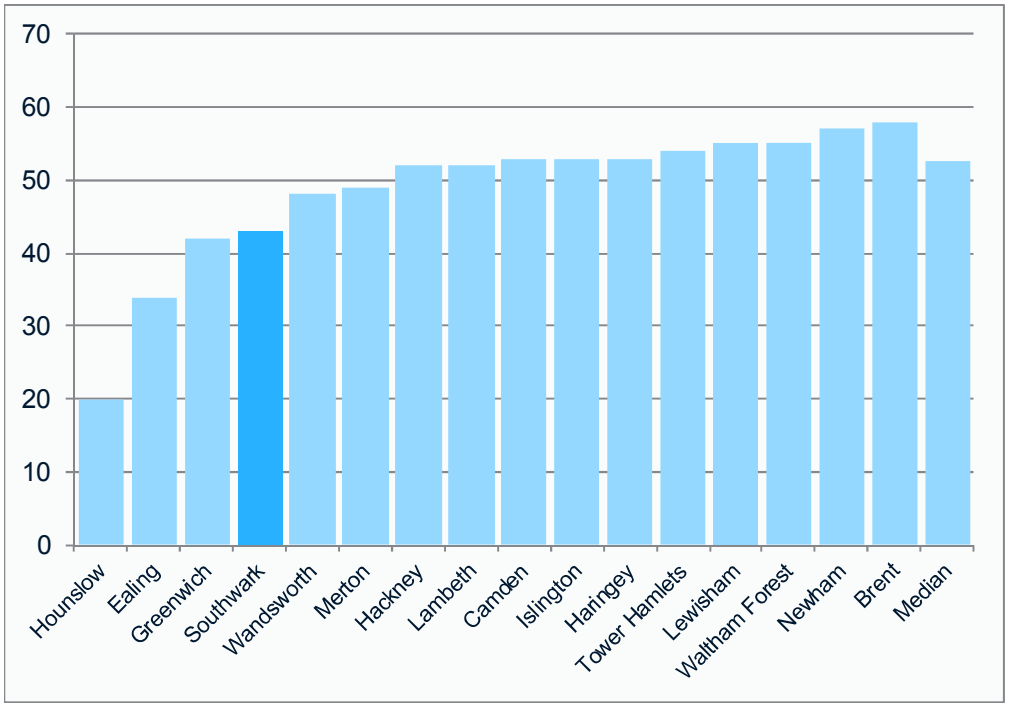
3.2 Of the concluded referrals with location identified, the percentage where the abuse took place in a care home

Council (in rank order)	No
Hackney	11
Haringey	12
Newham	15
Tower Hamlets	16
Camden	19
Wandsworth	19
Hounslow	21
Islington	22
Waltham Forest	22
Southwark	23
Lambeth	24
Ealing	26
Lewisham	27
Greenwich	29
Brent	31
Merton	45



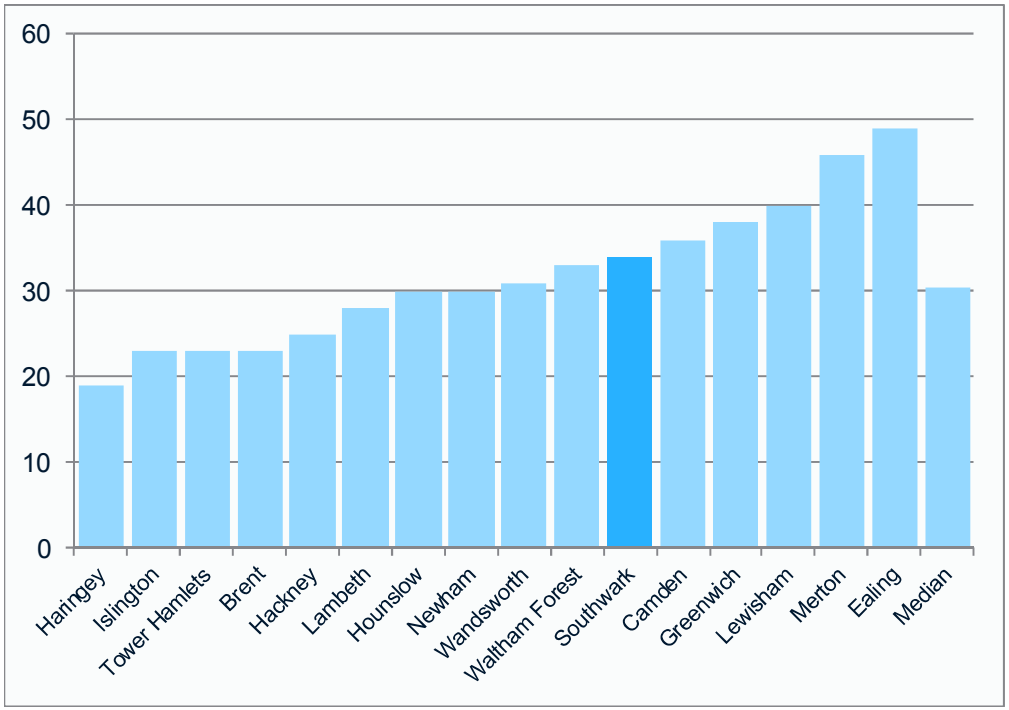
3.3 Of concluded referrals, the percentage where source of risk was known to the individual but not in a social care capacity

Council (in rank order)	No
Hounslow	20
Ealing	34
Greenwich	42
Southwark	43
Wandsworth	48
Merton	49
Hackney	52
Lambeth	52
Camden	53
Islington	53
Haringey	53
Tower Hamlets	54
Lewisham	55
Waltham Forest	55
Newham	57
Brent	58
Median	52.5



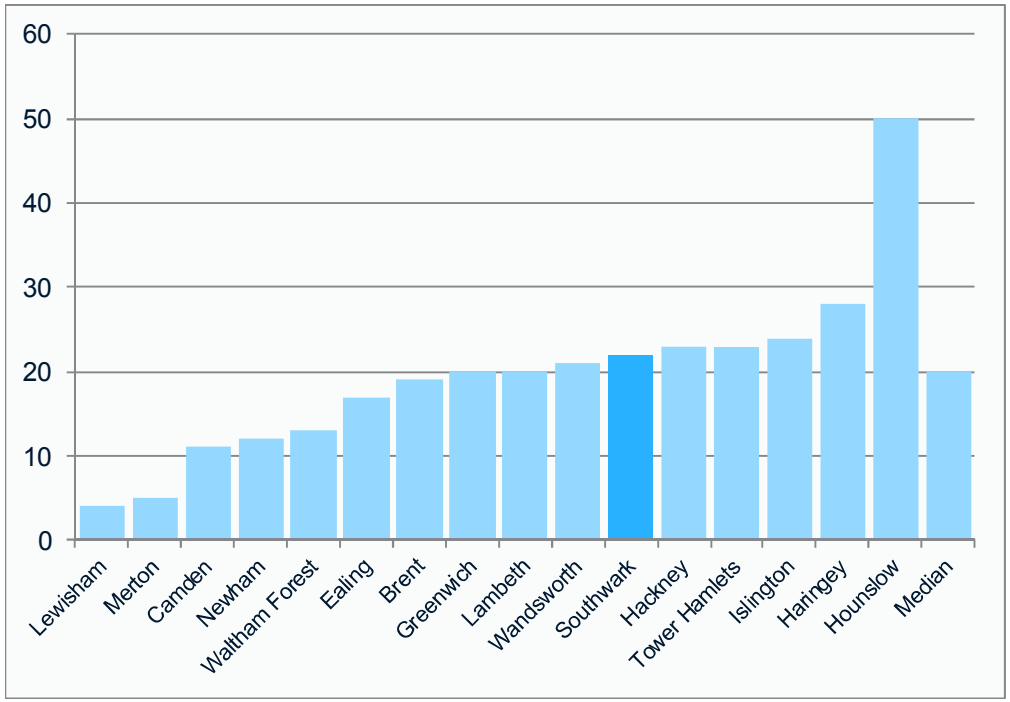
3.4 Of concluded referrals, the percentage where the source of risk was a social care employee

Council (in rank order)	No
Haringey	19
Islington	23
Tower Hamlets	23
Brent	23
Hackney	25
Lambeth	28
Hounslow	30
Newham	30
Wandsworth	31
Waltham Forest	33
Southwark	34
Camden	36
Greenwich	38
Lewisham	40
Merton	46
Ealing	49
Median	30.5



3.5 Of concluded referrals, the percentage where the source of risk was unknown to the individual

Council (in rank order)	No
Lewisham	4
Merton	5
Camden	11
Newham	12
Waltham Forest	13
Ealing	17
Brent	19
Greenwich	20
Lambeth	20
Wandsworth	21
Southwark	22
Hackney	23
Tower Hamlets	23
Islington	24
Haringey	28
Hounslow	50
Median	20



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Agenda Item 15

Item No. 15.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Lambeth, Southwark and Lewisham Sexual Health Strategy and Consultation	
Wards or groups affected:		All	
From:		Elizabeth Clowes, Asst Director, Commissioning EClowes@lambeth.gov.uk; Andrew Billington, Lead Commissioner, LSL HIV and Sexual Health Commissioning Team	

RECOMMENDATIONS

1. The board is requested to:

   - Review the responses to the public consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy (Appendix 1 of the report).

   - Agree the Lambeth, Southwark and Lewisham Sexual Health Strategy (Appendix 2 of the report).

EXECUTIVE SUMMARY

2. This report summarises the contents of the Lambeth, Southwark and Lewisham Sexual Health Strategy, which was launched in April 2014 for a period of consultation, including presentation at boroughs' relevant scrutiny or health committees.

3. The strategy is based on a public health needs assessment, covers analysis of investment and service delivery and makes recommendations regarding a direction of travel for shifting investment from clinic-based services to community provision and prevention and promotion.

4. The strategy has been developed with input from stakeholders, and consultation has included engagement with Clinical Commissioning Groups (CCGs) and specific focus groups with young people, MSM (men who have sex with men) and black and ethnic minorities.

BACKGROUND INFORMATION

5. From April 2013, as a result of the Health and Social Care Act 2012, the responsibility for population based health improvement through the provision of Public Health specialist advice, strategic responsibility and the commissioning of a range of health improvement services transferred to local authorities. The duties are covered by Part 2 of the Local Authorities (Public Health Functions and Entry into Premises by local Healthwatch representatives) Regulations 2013, which sets out specific duties regarding public health advice services, weighing and measuring of children, health checks, and sexual health services and protecting the health of the local population.

6. These duties were transferred from Primary Care Trusts (PCTs) and the interventions and services commissioned cover all the population for universal access as well as targeted services, and include specialist targeted areas such as sexual health and substance misuse services.

7. The provision of Public Health specialist advice now operates across the two boroughs of Southwark and Lambeth; it is a shared service hosted by Southwark Council. Lambeth Council is the host for a small sexual health commissioning team which operates across Lambeth, Southwark and Lewisham (as was the arrangement in the PCT). Lambeth is also host for the London-wide HIV prevention programme, which is high-level and high-profile, and led by the London Directors of Public Health. Other commissioning arrangements for children, health and well-being (or staying healthy) and substance misuse are borough-based, but have some alignment with Southwark to varying degrees.

8. The commissioning service, hosted by Lambeth, is governed by a three borough Board, chaired by Kerry Crichlow, Strategic Commissioning Director for Adults and Children's' Services in Southwark. The Council is responsible for commissioning open access GUM provision, sexual health prevention and promotion, community contraception, and sexual health in pharmacies and primary care. The 3-borough team also commissions termination of pregnancy services and HIV care and support on behalf of the Clinical Commissioning Groups.

9. Lambeth, Southwark and Lewisham have some of the poorest sexual health in the country. Southwark was ranked 3 (out of 326 local authorities, first in the rank has highest rates) in England for rates of acute STIs in 2012, with 6350 acute STIs diagnosed (a rate of 2199.4 per 100,000 residents). In Southwark, 38% of diagnoses of acute STIs were in young people.

10. London local authorities account for 18 out of the 20 local authorities with the highest diagnosed prevalence rate of HIV in the country. In 2012, for Southwark diagnosed HIV prevalence was 11.7 per 1,000 population aged 15-59 years. Recently released Public Health figures show increases in serious STIs such as gonorrhoea, which has increased nationally by 15%, and by 26% in the MSM population, with treatment-resistant strains becoming an increasing problem.

11. Against this background, the Commissioning Board had a priority to develop a three-borough sexual health strategy, to tackle high levels of need and set clear prevention and promotion programmes in place. The strategy builds on previous LSL strategies, achievements and work of Modernisation Initiative. An initial stakeholder engagement day in September 2013 helped to build the local strategic priorities. Following extensive commissioning and public health engagement, a draft strategy was finalised and launched for consultation in April 2014.

12. The strategy sets out the local HIV and sexual health landscape, assessing previous strategies, financial resources and sexual health services in Lambeth, Southwark and Lewisham, as follows:

    - Promotion and prevention
    - Sexual health services/GUM/psychosexual
    - Primary Care

- HIV Care and support
- Termination of pregnancy (abortion)
- Young peoples services & teenage pregnancy

13. The strategy sets out the following vision and strategic priorities:

- Embedding good sexual health and wellness as part of a wider health agenda
- Actively promoting good sexual health and healthy safe relationships, not just the absence of disease
- Reducing the stigma attached to sexually transmitted infections (STIs)
- Focusing on those statistically most at risk thereby reducing health inequalities
- Reducing the rates of unplanned pregnancy and repeat terminations, especially for under 18 year olds
- Reducing rates of undiagnosed STIs and HIV
- Aligning strategic priorities with the intentions of our local CCGs
- Developing the workforce to deliver integrated and improved services
- Shifting the balance of care to community-based services that are accessible and responsive to the needs of service users

14. The strategy consultation ended 31 July 2014. The Strategy was available on local websites. CCGs were included in consultation, and specific focus groups were held in each borough for men who have sex with men (MSM), black and ethnic minorities and young people, the three strategic priority groups. The responses to the consultation were reviewed by the LSL HIV and Sexual Health Commissioning team and Specialist Public Health Consultants, who responded to the feedback and agreed any changes.

KEY ISSUES FOR CONSIDERATION

Consultation and co-production

15. The Strategy was co-produced following a stakeholder event attended by over 100 stakeholders representing a diversity of organisations and communities in September 2013. Key areas of sexual health were discussed with providers from the NHS and voluntary sectors, service users, public health colleagues and others. The draft strategy was launched at a further stakeholder event in April, and was subject to wide-ranging consultation across the three boroughs. During the consultation the Strategy was available on the Lambeth Council website and, via a link, on the Lambeth, Southwark and Lewisham CCG and Council websites, with a dedicated email and online form for responses.

16. The Strategy has identified three key target user groups: MSM, young people and Black minority ethnic communities. Focus groups were held in each borough with these groups to discuss the Strategy and gain feedback. The strategy was reviewed by primary care networks, by the 3 borough Local Medical Committees and Local Pharmacy Committees and presented to each relevant scrutiny committee, all of whom gave detailed feedback. Healthwatch in each borough has been engaged and responded with detailed feedback. Detailed feedback was also received from local voluntary sector organisations, local NHS (including providers of clinical sexual health services) and children and young people's services.

17. The overall consultation response endorsed the aims and vision for the Strategy, recognising the need to shift investment from treatment into prevention, and supported the move towards commissioning services that were delivered closer to home. Key concerns that were raised by the consultation are summarised below along with the consultation response and changes that are being made as a result on the consultation:

- Why does the Strategy adopt a medical model and focus on services?
  Reponse: The focus on services, and reshaping services, is key to delivering better outcomes for residents. The plan to shift to community-based services is central to the Strategy and community engagement and involvement is key to bringing about this change.

- How will Community and Voluntary Sector Organisations (CVSO) be involved in delivering the Strategy
  Response: CVSOs will remain central to delivery on the aims of the Strategy and future commissioning, for example, in the procurement of new prevention services. There are community forums and networks in LSL that can support delivery of the Strategy, for example, the Sexual Health Network and African Health Forum. Work will be undertaken to review how to best support the work of existing networks to deliver on the aims of the Strategy. Detailed plans for community and stakeholder engagement, involvement and activation will be included in the Implementation Plan

- Is there sufficient evidence to identify what works to inform commissioning, including for work with African communities and men who have sex with men (MSM)?
  Response: Overall, evidence in relation to work with African communities suggests that a multi-component approach to prevention and sexual health promotion is most effective. The Strategy is informed by a service review of SRH and the epidemiology report, which also constitutes a needs assessment. The Strategy sets a direction of travel which includes a shift to self-management, online services and primary care to meet less complex needs. This is widely accepted as offering best value and as increasing patient choice, as backed up by evidence from evaluation and service-user feedback. New service models, including innovative on-line services, will be fully evaluated during development. Partnership work wil support further research, looking for best value, particularly given the current financial climate.

- Is there a commitment to protecting open access services and patient choice?
  Response: The Strategy aims to extend patient choice by extending access to services so that people continue to access sexual health services via open access clinical services as well as an additional range of other community and online services.

- Will there be a review of primary care?
  Response: There is a need for a review of sexual health work within primary care as part of the work needed to drive forward the vision of the Strategy. An LSL Sexual Health Commissioning Board Primary Care sub-group will deliver this work.

- Is there a commitment to supporting workforce development?
  Response: There is an on-going need for staff in mainstream services to be trained in HIV and sexual health. Also, many staff in mainstream services may already process related skills and knowledge but should have access to training to maintain and develop them. Further detail of proposals to take forward workforce development will be included in the Implementation Plan

- How can high quality SRE be delivered in all schools?
  Response: There is currently extensive work across LSL aimed at ensuring high quality SRE is delivered in all schools and colleges. Work will continue with colleagues in young people's services and education to promote access to quality SRE

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- Will work related to Hepatitis prevention and Female Genital Mutilation(FGM) be commissioned?
  Response: Detail on commissioning in relation to Hepatitis and FGM be included in the Action Plan

18. The full response document is available as an Appendix to this report.

19. The consultation endorsed the Strategy's overall direction of travel. As a result of the response there will be additional emphasis in the Action Plan on: female genital mutilation; Hepatitis; workforce development; co-working with colleagues outside of sexual health; and involving the community and voluntary sector in delivery of the Strategy.

Policy implications

20. There are no specific implications arising.

Community and equalities impact statement

21. An Equalities Impact Assessment has been finalised which incorporates the response to the consultation.

Legal implications

22. There are no specific legal implications arising but it should be noted that, with effect from 1 April 2013, local authorities are required to ensure that comprehensive, open access, confidential sexual health services are available to all people who are present in their area whether resident in their area or not.

Financial implications

23. Over the last few years NHS and local authority services budgets have consistently had to find cost-efficiencies whilst the demand for their services have grown. Although public health budgets transferred to local authorities have been ring fenced for at least two years from April 2013, given the present economic climate it is imperative that all locally commissioned sexual health services are cost effective and deliver measurable outcomes. To achieve this LSL sexual health commissioning team will work with local partners to avoid duplication and to commission and deliver evidence based, needs led, responsive sexual health services.

24. In 2013/14, Southwark's budget for clinical services was £10,800m, with cost pressures in demand-led Genitourinary Medicine (GUM clinic presentations). Spend on prevention and promotion was £242K, and £287K on primary care and pharmacy. A total of over £27m was spent on sexual health services across Lambeth, Southwark and Lewisham, mainly on clinic-based GUM services. Steps have been put in place in to drive down price and demand. New contracting mechanisms will be introduced that will contain spend for 2014/15, and onwards, whilst services will be reshaped to shift activity to community settings where they are more cost-effective and deliver better health outcomes. For example, basic sexual health services will be provided in community pharmacy where they will be more accessible and offer better value for money. All services will be underpinned by prevention. With the lifetime cost of HIV treatment estimated at £276,000 the health economics argument to invest in sexual health services to prevent such infections and, for example, unintended pregnancy are clear, and the direction of the strategy is to shift resources to prevention and promotion.

REASONS FOR URGENCY

25. Sexual health is a national and local public health priority. Lambeth, Southwark and Lewisham are working together to commission services in a tri-borough agreement. The Southwark Health and Wellbeing Board is being requested to consider the consultation responses and to agree the Lambeth, Southwark and Lewisham Sexual Health Strategy 2014 – 2017. It is imperative that the board considers the strategy as soon as possible so to enable it to endorse the strategy in line with the other boroughs.

REASONS FOR LATENESS

26. It was not possible to finalise the officer report prior to the deadline for the agenda despatch.

BACKGROUND PAPERS

Background Papers	Held At	Contact
LSL Sexual Health Strategy 2014-2017	See link below	ABillington@lambeth.gov.uk
Link: http://lambeth.gov.uk/social-support-and-health/lambeth-southwark-and-lewisham-sexual-health-strategy		

APPENDICES

No.	Title
Appendix 1	Responses to the Consultation on Lambeth Southwark and Lewisham (LSL) Sexual Health Strategy 2014-2017: A Summary Report
Appendix 2	LSL Sexual Health Strategy 2014 -2017

AUDIT TRAIL

Lead Officer	Elizabeth Clowes, Assistant Director, Commissioning *EClowes@lambeth.gov.uk*		
Report Author	Andrew Billington, Lead Commissioner, LSL HIV and Sexual Health Commissioning Team, ABillington@lambeth.gov.uk		
Version	Final		
Dated	22 January 2015		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Legal Services		No	No
Strategic Director of Finance and Corporate Services		No	No
Date final report sent to Constitutional Team			22 January 2015

APPENDIX 1

Responses to the Consultation on Lambeth Southwark and Lewisham Sexual Health Strategy 2014-2017: A Summary Report

1 The Development of the Strategy and the Consultation Process

A stakeholder consultation event was held in October 2013. The outputs from this event informed the content of the draft strategy. The consultation process comprised of:

- Strategy placed on Lambeth Council website with links from all LSL CCGs and Council websites inviting feedback via email, feedback form or letter.
- Consultation launch event held in April 2014 attended by stakeholders to secure views on the draft strategy.
- 9 focus groups in LSL (3 groups in each borough) with the Strategy priority groups ie with men who have sex with men (MSM), young people and Black African people
- Attendance at LSL Scrutiny and Oversight Committees, CCG Boards, Primary Care Network Meetings, LGBT Forum to present Strategy and invite feedback

2 The Response to the Consultation

Responses were received from:

- LSL Local Medical Committee
- LSL Local Pharmaceutical Committee
- Guy's and St Thomas' NHS Foundation Trust Sexual and Reproductive Health Department
- Lewisham & Greenwich NHS Trust Directorate of Sexual Health & HIV
- Department of Sexual Health and HIV Kings' College Hospital
- Southwark Young People's and Children's team
- Lewisham Public Health and GP Wells Park Practice
- Lambeth CCG
- Lewisham CCG
- 3 Boroughs Health Inclusion Team, Guy's and St Thomas' NHS Foundation Trust
- Public Health Manager - Sexual Health & Immunisation
- WUSH (Wise Up to Sexual Health)
- Kings Health Partners
- Body and Soul
- Metro Centre
- National AIDS Trust
- HIV Clinical Nurse Specialist team, Guy's and St Thomas' NHS Foundation Trust
- Southwark LGBT Network
- African Advocacy Foundation

- Naz Project
- Positive Parenting and Children
- Beth Centre
- Brook (2 responses)
- Lambeth, Southwark and Lewisham Healthwatches (combined response)

A combined response was received from:

- Head of Service, Permanence, Southwark Children & Adult's Services
- Head of Service, Assessment, Southwark Children & Adult's Services
- Advanced Practitioner, Assessment Service Pre-Birth Team Southwark Children & Adult's Services
- Consultant in Community Sexual Health and HIV GSTT
- Head of Nursing, Addictions Clinical Academic Group South London & Maudsley NHS Foundation Trust Addictions Senior Management Team
- STARP Partnership Coordinator
- Associate Psychiatric Specialist Addictions, South London and Maudsley NHS Foundation Trust
- Deputy General Manager Sexual & Reproductive Health
- Specialist Registrar, Sexual & Reproductive Health GSTT
- Team Manager, Learning Disability Team
- Team Manager Transition Team (children & adults with Disabilities
- Head of Troubled Families
- Manager, Sexual Health Outreach for Young People & Sexual Health Promotion
- Adult Mental Health

3 Review of the Responses

The responses were reviewed by the LSL HIV and Sexual Health Commissioning team and Specialist Public Health Consultants, who will be responsible for delivering on the commitments made in the document.

This document synthesises and summarises responses and addresses them by themes. It also details all corrections and requests for clarification.

No.	Summary of feedback	Response	What we will do
Theme 1: Aims, Vision and Content			
1.1	Request that the strategic aims include: • Addressing HIV stigma	We recognise the value of all the aims proposed. However, based on evidence of need and epidemiology the strategic aims we state in the	We will address all the proposed aims within work outlined in the Implementation Plan

	• Reducing late diagnosis • Enhancing quality of life for PWHIV • Ensuring services accessible to all	Strategy remain our priority aims.	
1.2	Request for greater detail on governance arrangements for LSL sexual health commissioning.	The governance arrangements are summarised briefly, as appropriate to a high-level document	No proposed action
1.3	Request that the Strategy includes more detail on partnership working with other commissioning teams and bodies, other organisations, including non-sexual health services and on links with other local strategies.	We acknowledge that there are strong links between the Strategy and other LSL strategies. We acknowledge that collaborative working with other teams, services and organisations will play a key role in delivering on our aims	We will reference linked LSL Strategies and other relevant frameworks in the Implementation Plan. We will detail where we will work closely with others to deliver on our aims in the Implementation Plan. We will identify opportunities for the upskilling of workforces in non-sexual health settings to deliver on sexual health outcomes
1.4	Concern that the Strategy adopts too much of a medical model and focuses too much on services. Requests that the Strategy adopt a more holistic or life-course approach with a greater emphasis on community activation, education and empowerment.	We focus on services, as reshaping services is key to delivering better outcomes for LSL residents. We plan to shift to community-based services wherever they best meet need and acknowledge that community engagement and involvement is key to bringing about this change (we name this as best practice at 4.2.1).	We will include detail on community engagement, involvement and activation in the Implementation plan
1.5	Concern that here is too not enough emphasis on HIV or on sexual health.	We believe we have reached a balance in the content and aspirations included in the Strategy in relation to HIV and sexual health	No proposed action
1.6	Concern that there is not enough emphasis placed on each of the priority groups, or that there is too much emphasis placed on one at the expense of the others	We believe we have reached a balance in the content and aspirations included in the Strategy in relation to all the priority groups.	No proposed action
1.7	Concern that other vulnerable groups be named and prioritised in the Strategy: • Latin American people • People with sensory impairment, especially gay men	We acknowledge there are groups other than those we name as priorities who experience poor sexual health. In addition we note that LSL has fluid populations and it is important our services are accessible to these groups. However, the key priority for our work remains those groups most at risk in LSL,	We will work with colleagues and in partnerships to address the needs of other groups who experience poor sexual health

	• Women who have repeatedly lost the care of their children to others, or those at risk • Lesbian and bisexual women • Trans individuals	as identified in the Strategy, given the epidemiology.	
1.8	Concerns that the Strategy treats the priority groups named as homogenous and that this approach will influence the commissioning of services for these groups.	We acknowledge that the priority groups named in the Strategy have multiple identities and needs.	We will commission services that recognise the overlapping and multiple needs of LSL residents.
1.9	Request that blood born viruses other than HIV, including Hepatitis B and C, be included in the Strategy and for female genital mutilation (FGM) to be included in the Strategy	Noted	We will include Hepatitis and FGM in the Implementation Plan
1.10	Request for a dedicated section on improving health in Lewisham or a separate Strategy	Whilst there are differences between the 3 boroughs they are broadly similar. Commissioning across all three boroughs offers best value and quality, economies off scale and efficiencies. It also still allows for the commissioning of local services to meet local needs.	No proposed action
Theme 2: Community and Voluntary Sector Organisations (CVSO)			
2.1	Request for greater detail on how CVSOs, stakeholder, services users and residents will be involved in delivering the aims of the Strategy, including their role in workforce development. Request for new sector networks and forms to be set up to support delivery eg LSL Health Forum	CVSOs will remain central to delivering on the aims of the Strategy and future commissioning eg in the procurement of new prevention services. There are forums and networks in LSL that include CVS representation and that can support delivery of the Strategy eg Sexual Health Network. African Health Forum	We will review how to best support the work of existing networks to deliver on the aims of the Strategy
Theme 3: Evidence and evaluation			
3.1	Concern that there is insufficient evidence about needs and services, including robust service evaluation and focus on 'what works', particularly in relation to African communities. Concern that there is insufficient evidence, including cost analysis, stated in the strategy to underpin the	Overall, evidence in relation to work with African communities suggests that a multi-component approach to prevention and sexual health promotion is most effective. The Strategy is informed by a service review of SRH and the epidemiology report, which also constitutes a	New service models, including innovative on-line services, will be fully evaluated during development. There is local research available which we will access to inform service developments

	proposed strategy for commissioning sexual health services	needs assessment. The Strategy sets a direction of travel which includes a shift to self-management, online services and primary care to meet less complex needs. This is widely accepted as offering best value and as increasing patient choice, as backed up by evidence from the private sector evaluation, service-user feedback.	We will use learning from previous innovative work, for example from the Modernisation Initiative, to inform our commissioning. We will work with partners to support further research, looking for best value, particularly given the current financial climate.
Theme 4: Stakeholder Involvement and Engagement			
4.1	Request for detail on the consultation that informed the development of the Strategy.	The consultation on the Strategy was broad and diverse. For full details see the introduction to this document.	No proposed action
4.2	Request for detail on plans for stakeholder involvement and engagement in the delivery on the aims of the Strategy, including on any plans to change services.	We recognise stakeholder involvement and engagement as central to the delivery of the Strategy. Stakeholder engagement will be central to decisions around service change.	We will include detail on how we will collaborate with the CCG and involve CVSOs, stakeholder, services users and residents in the delivery of the aims of the Strategy in the Implementation plan.
4.3	Concern that faith leaders are fully engaged in delivery on the aims of the Strategy	We acknowledge the importance of working with faith leaders in the Strategy. The detail of how we commission services to encompass this will be included in subsequent planning	We will include a focus on commissioning services that take the role of faith leaders into account in the Implementation Plan
Theme 5: Service Development and Redesign			
5.1	Request for a more detailed vision to be cited alongside an optimal model for sexual health and psychosexual services and detail on how this will be achieved.	The vision is high level and describes our direction of travel towards commissioning services that more-community-based and support better self-management.	The Implementation Plan will detail the steps we will take to implement the vision.
5.2	Information on sexual health and community services is hard to access and often not accurate	We acknowledge that accessing accurate service information is currently problematic	We are prioritising the commissioning of services that will include a focus on providing signposting to services
5.3	Concern there should be a stronger commitment to protecting open access services clinical services and that any changes to services do not reduce quality,	The Strategy aims to extend patient choice by extending access to services so that people continue to access sexual health services via open access	No proposed action

	restrict patient choice or are not delivered at the expense of other services	clinical services as well as an additional range of other community and online services. Any change in service configuration will be accompanied by an assessment of the impact on service users in relation to access.	
5.4	Request for detail on future investment in care and support for people living with HIV (PLWHIV), in sexual health services and on how money will be shifted from sexual health services into prevention.	We will continue to invest in care and support for PLWHIV and in sexual health services. However it is impossible to sustain the current levels of funding for sexual health services. We must therefore look to service-redesign and a shift to prevention to ensure we meet the needs of LSL residents rather than looking to additional investment.	We will include plans for commissioning care and support services for PLWHIV in the Implementation Plan. We will include the steps we will take to reshape sexual health services in the Implementation Plan.
5.5	Request for sexual orientation and gender monitoring to be included in service commissioning plans.	We acknowledge the importance of monitoring with the aim of addressing inequalities.	We will work with providers to improve monitoring regarding equalities.
5.6	Young people want a greater choice on where to access sexual health services	The Strategy outlines our commitment to extending choice through service innovation.	No proposed action
Theme 6: HIV Prevention and HIV Testing			
6.1	Request for detail on which HIV prevention interventions, including which models and approaches, will be commissioned.	The detail of HIV prevention interventions we will commission will be included in subsequent commissioning plans. Our commissioning will be outcome-focussed	We will include more detail on HIV prevention we will commission in the Implementation Plan
6.2	Request for a commitment to introducing HIV testing in all possible settings, including acute medical settings, and widening access to same day testing.	We make a commitment to introducing HIV testing in a variety of settings.	Future commissioning plans will prioritise rolling out HIV testing in all viable settings. We will work with CCG partners to ensure we maximise opportunities to extend this into acute medical settings
6.3	Request that the Strategy notes that clinical services also deliver prevention work.	We acknowledge that important prevention work is undertaken in sexual health services. However, we prioritise prevention work in the community which reduces the need for clinical treatment and care.	No proposed action
Theme 7: Primary Care			
7.1	Request for review of primary care with a view to identifying detail on how and which sexual health	We acknowledge the need for a review of sexual health work within primary care as part of the work	We will include detail of the Primary Care sub-group in the Implementation Plan

	services it can best provide.	needed to drive forward our vision. An LSL Sexual Health Commissioning Board Primary Care sub-group will drive this work and review the questions raised by the consultation	
7.2	Concern that certain groups (eg LGBT people, PLWHIV) are not always comfortable accessing sexual health services via primary care and express concerns related to patient confidentiality, especially compared to GUM and RSH services.	We recognise that some service users prefer to use specialist services. The strategy suggests a diverse range of options for care and self-management. We know from previous research that over 85% of PLWHIV share their HIV status with their GP. The same rules of confidentiality apply to all NIS clinicians wherever they work	All the services we commission deliver to the same standards of care. We will work to improve perceptions of confidentiality across all services
7.3	Note that pharmacies already have established relationships with substance misuse services and with vulnerable groups and are ideally placed to offer sexual health services.	We agree. Hence our intention to expand sexual health service provision in pharmacies	No proposed action
Theme 8: Workforce Development			
8.1	Request for detail on the workforce development that will be commissioned to support delivery of the strategy, with a variety of training and education proposed.	We acknowledge the importance and value of all the training named in the feedback. We will work with the SE London sexual health Network to develop workforce training across LSL.	We will include further detail of proposals to take forward workforce development in the Implementation Plan
8.2	Request that the re-balancing of specialist and mainstream services for PWHIV includes training staff in mainstream services to better meet the needs of PWHIV, including a focus on primary care.	We acknowledge there is an on-going need for staff in mainstream services to be trained in HIV and sexual health. However, we also recognise that many staff in mainstream services already process related skills and knowledge but should have access to training to maintain and develop them.	We will include further detail of proposals to take forward workforce development in the Implementation Plan
8.3	Request for detail on how Making Every Contact Count will be extended to all workforces and volunteers involved in sexual health	Noted	We will work with Local Authority and Health colleagues on proposals for taking forward Making Every Contact Count
Theme 9: Young People			
9.1	Request for ensuring high quality SRE provision in all schools	There is currently extensive work across LSL aimed at ensuring high quality SRE is delivered in all schools and colleges.	We will continue to work with colleagues in young people's services and education to promote access to quality SRE.

9.3	Concern that services for young people should be inclusive and welcoming.	We are committed to making services for young people inclusive and welcoming, eg we reference 'You're Welcome' Young People Friendly standards	We will include Young People Friendly standards, and a requirement to ensure services are fully inclusive in commissioning and procurement plans
Theme 10: Condom Distribution			
10.1	Request for detail on how the proposed condom distribution scheme will be more effective than the current scheme, especially as adults and young people may have differing needs.	We have outlined the benefits of a centralised LSL condom distribution scheme in Appendix 6 Summary of Review of Condom Distribution Schemes, 2013.	We will include further detail of centralised LSL condom distribution scheme in the Implementation plan
10.2	Request on how the London-wide MSM condom scheme delivers for Southwark when there are no LGBT venues in Southwark	The London-wide HIV Prevention Programme MSM condom scheme delivers condoms to LGBT venues across London. Residents of Southwark visit these venues. The scheme targets limited resources at those venues where condoms are most needed eg Sex on Premises venues.	No proposed action
Theme 11: Termination of Pregnancy (TOP)			
11.1	Concern that women over 40 should also be a focus for reducing TOP	Women under 25 remain our priority focus. As with all our work we review and adjust if necessary, according to epidemiology.	No proposed action
12: Corrections			
12.1	P4, under the heading 'Teenage pregnancy and young people'-did you mean to say Lambeth rather than Lewisham, for rates that are falling?	Noted	Revised in final version
12.2	P12 only Lewisham's repeat TOPs are stated here, though they are then stated for all three boroughs on p19.	Noted	Revised in final version
12.3	P47 suggests Brook has more funding than it does. Under clinical services the figure should be the ones cited under 'prevention', of £264,921 and £276,419. Under prevention, C Card is correct, but 'Brook sexual health service' should read £100k for being part of the Lambeth HWB programme.	Noted	Revised in final version
12.4	Section 4.3.1 requires a correction about level 3	Noted	Revised in final version

	GUM services. Since the appointment of GUM consultant in the community SRH service in 2010, the service provided most of the elements of a level 3 GUM service similar to 100 Denmark Hill and Lewisham		
12.5	There is an error in the second key message in section 4.5.1. It rightly talks about shifting medical gynaecology to a community setting [which needs redirection of funding to community as in the current contract in our Southwark medical gynaecology service] but the governance, oversight of the pathway and training is the remit of SRH units not GUM as the SRH service has gynaecologically trained specialists. GSTT SRH currently provide a prolapse/ring pessary service, deals with all women with Premenstrual syndrome referred to the acute unit and provides an extensive psychosexual service; all under the block contract, an anomaly that needs addressing	Noted	Revised in final version We will aim to address this situation working with CCG partners
12.6	"Local community sexual health integrated services now provide level 2 STI management and level 3 contraceptive provision. Also, Lewisham has had a level 3 community based GU service since November 2012, integrated into the Lewisham community SRH service (which also provides level 3 contraception). Kings College Hospital provides level 3 sexual health provision and level 3 contraceptive provision. In 2011, Southwark and Lambeth community sexual health services were brought together under one management structure into GSTT as part of its community directorate. Community services will be merged with GSTT GUM services to create an integrated service in 2014. Lewisham community sexual health service is now part of the new Lewisham & Greenwich Trust, created in October 2013, which also includes the	Noted	Revised in final version

	GUM service at Queen Elizabeth Hospital in Woolwich." The above section does not accurately reflect the situation in Lewisham at the present time. Lewisham Sexual and Reproductive Health services merged with the acute hospital trust in April 2010 and at that time were providing SRH to level 3 and GUM to level 2. In November 2012 a level 3 GUM service was launched, with the intention of transitioning to a fully integrated level 3 GUM and level 3 SRH service in the community. When Lewisham and Greenwich NHS trust was created in October 2013, the SRH and GUM service at Lewisham merged with the GUM service at the Trafalgar Clinic, which is based in the Queen Elizabeth Hospital in Woolwich		
12.7	4.4 Genitourinary Medicine (GUM) Services "LSL residents tend to attend GUM services outside of the boroughs. Less than half of Lambeth residents attended Lambeth or Southwark based GUM clinic (St Thomas, King's or Guy's hospital). In Lewisham the main reason is the absence of GUM services in Lewisham." As previously noted, Lewisham does have a GUM service, which is located within the community SRH service and provides level 3 GUM. So this may have been a historical reason why some Lewisham residents did not attend GUM services in their borough, but should not be the case going forward.	Noted	Revised in final version
12.8	"Unplanned pregnancy" is used synonymously with "unwanted pregnancy" – the 2 are by no means the same.	Noted	Revised in final version
12.9	The figures for late diagnosis of HIV infection, 39%, 45% and 52% seem to contradict P12 which appears to say that Lambeth / Southwark Late diagnosis of	Noted	Revised in final version

	HIV is 15% – Should it be 'reduce late diagnosis of HIV 'by' 15% by 2010-11?		
12.10	P18 Table 9 – blue. 2nd box down Needs rewriting e.g. Conceptions per 1000 young women aged 15-17yrs (2012) – at present it doesn't really make sense nor mirror other wording.	Noted	Revised in final version
12.11	P19 – 1st Paragraph Faraday needs to be Faraday	Noted	Revised in final version
12.13	P23 Lowest paragraph, 3rd point '….. prompt access to Emergency contraception and LARC methods (e.g. IUD, injection, implants)' As the paragraph is written now it suggests that injectables / implants can be accessed as Emergency contraceptive LARC method	Noted	Revised in final version
12.14	When you refer to people with 'learning difficulties' you mean 'learning disabilities'	Noted	Revised in final version
12.15	On final Table, need additional crosses as HPV occurs in Primary care too. Young people seen for sexual healthcare in Primary care too And IUD, Sex workers, Asylum seekers and the homeless, I am not sure why these have been omitted from the GP setting.	Noted	Revised in final version
13: Clarifications			
13.1	P20 I am not sure why 'Older people' is on the list for vulnerable to poor sexual health and to be targeted	Certain groups of older people have greater sexual need. They are not one of our priority groups but will form part of some of our priority groups eg older MSM	No proposed action
13.2	The term MSM should not be used as it does not reflect the cultural context and validity of the gay and bisexual community	We use the term MSM within this document given the Strategy's focus on sexual behaviour in the context of sexual health promotion. It is also used for concision.	We will include a footnote in the Strategy to explain why we use the term MSM
13.3	Request for detail on any Equality Impact Assessment of the being carried out as part of the Strategy development	We are currently updating the Equality Impact Assessment of the Strategy.	The Equality Impact Assessment will be published on the Lambeth Council website

13.4	There is a confusion of terminology and meaning. All sexual health services should now be integrated services – and it is unclear what is meant by 'integration'.	The Strategy refers to sexual health services according to how they are commissioned, either as GUM or as RSH.	We will add a footnote in the Strategy to explain the terminology
13.5	'Not getting HIV in the first place' is too blunt and pejorative as a definition of primary prevention	We used the phrase for purposes of clarity	No proposed action
13.6	How can HIV treatment services and SARCs be out of scope for prevention?	LSL Councils are not responsible for commissioning HIV treatment services and SARCs. We recognise that prevention should be delivered from these and other settings and we will work with NHSE and other commissioning bodies to influence their commissioning of prevention work in these settings	No proposed action
13.7	Will WUSH be rolled out across LSL?	WUSH is commissioned to provide services in Lambeth and Southwark. However, elements of the programme may be delivered in other boroughs. A range of other services for young people are commissioned in Lewisham	No proposed action
13.8	Are there action plans to reduce teenage pregnancies?	All three boroughs have plans to reduce teenage pregnancy. These remain the responsibilities of individual boroughs. In addition unplanned pregnancy affects other age groups, for whom we provide information and access to options	No proposed action
13.9	There is inconsistency in the use of the words 'abortion' and termination'	Noted	We will adopt 'termination'
13.10	Why are there no late TOP figures for Lewisham and Southwark?	Noted	This has been adjusted
13.11	Epidemiological data is not presented consistently across all three boroughs	Noted	We will present the data consistently across all three boroughs in the final version of the Strategy
13.12	The Strategy should reference links with 111	Noted	111 will be referenced within the Implementation Plan
13.13	Why is there no mention of CNS team, CASCAID and Mildmay?	Noted	Included in Implementation Plan

13.14	Please can you explain what 'Acute STI' means? It makes no sense to me as a clinician. It does not seem to be the total of all the other STI's in the table.	The definition of acute STI excludes HIV infection. It us used to describe the epidemiology of STIs. Generally it refers to cases of chlamydia, gonorrhoea, syphilis, warts and herpes. These are measured by incidence rates, ie new cases, whereas we tend to refer to the prevalence of HIV, as it is a chronic condition.	
13.15	P31, 'What we will do' box 4 What is 'wrap around primary care provision' can we clarify?	Wrap around primary care provision is sexual health services provided by primary care that aligns with specialist service provision	No proposed action
13.16	Why is there no national or local data on IDUs or sex workers?	Data on IDUs and sex workers is contained within other relevant Council and local NHS strategic and policy documents	No proposed action
13.17	The strategy needs to be updated to include recent plans on the tariff and a commitment to the integrated tariff	Noted	Updated detail on payment plans for sexual health services will be included in the Implementation Plan
13.18	The public health budgets should be included	The LSL HIV and sexual health budgets are included	No proposed action
13.19	RSH should continue to offer cytology screening given high rate of cervical cancer and patient choice	We acknowledge that cervical cytology is considered an integral part of good sexual and reproductive health service provision. GPs are commissioned and paid by NHSE to deliver cervical cytology. Whilst ideally this service will be offered through sexual health clinics there is currently no way of funding this capacity activity through the public health grant. Where clinics have the capacity to offer this service then commissioners may choose to continue with service provision but sites where patients are being tuned away it is more appropriate for GP's to be the first point of contact for smears.	No proposed action
13.20	Is there a referral pathway from community testing into care?	Yes. All organisations involved in community testing are required to have pathways into HIV clinics and have responsibility to ensure anyone identified as HIV positive is seen in clinics	No proposed action
13.21	Lewisham seems to do less via pharmacy but spends more on our pharmacy LES - double what Lambeth	This is partly because, historically, the other boroughs had age restrictions on emergency hormonal	No proposed action

	spends and nearly 1.5 times what Southwark spends	contraception (EHC), which was never the case in Lewisham. Pharmacies are used extensively in Lewisham for EHC whilst Southwark and Lambeth also have access via GP primary care, which Lewisham does not.	
13.22	Comparing the budget with the size of the population in each borough it appears that Lewisham is under-funded in comparison to Southwark and Lambeth	Financial data has now been revised for the final version. In addition, Lewisham has significantly lower HIV rates than Lambeth or Southwark (although they are still high), indicating that sexual health need is not quite so great.	No proposed action

APPENDIX 2

Sexual Health Strategy

2014-2017

Contents

Executive Summary

Context
Sexual health is a national and local public health priority. Lambeth, Southwark and Lewisham (LSL) have the highest rates of sexually transmitted infections, HIV and teenage conception rates in London and the UK. Promoting sexual health is complex. Improving access to, and the quality of, local sexual health services, can result in better sexual health outcomes and better value for money with respect to treatment. This requires an evidence-based commissioning approach, based on strong stakeholder engagement.

Public Health responsibility now sits with Local Authorities. LSL have taken a joint approach to commissioning sexual health services within a tri-borough agreement. The strategy is from 2014-17 and is in line with national, London and local sexual health priorities, policy and targets.

Vision
The vision is to improve sexual health in LSL by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities. A range of world class, needs-led services will target those most vulnerable in our boroughs. We will work towards our vision by:

- Embedding good sexual health and wellness as part of a wider health agenda
- Actively promoting good sexual health and healthy safe relationships, not just the absence of disease
- Reducing the stigma attached to sexually transmitted infections (STIs)
- Focusing on those statistically most at risk thereby reducing health inequalities
- Reducing the rates of unplanned pregnancy and repeat terminations, especially for under 18 year olds
- Reducing rates of undiagnosed STIs and HIV
- Aligning strategic priorities with the intentions of our local CCGs
- Developing the workforce to deliver integrated and improved services
- Shifting the balance of care to community-based services that are accessible and responsive to the needs of service users

We will ensure the service user voice is central, including supporting the work of the LSL Service User Reference Group (SURG).

Epidemiology
STI rates are high and continue to rise, particularly amongst MSM, young people and the Black African community. HIV prevalence is high and rising amongst MSM. These three groups are the priority overall for our work in LSL. Other, emerging vulnerable groups will require targeted interventions.

Finance
Public health commissioning responsibilities and associated resources transferred to local authorities in April 2013. Local authorities currently face an extremely challenging financial environment whilst cost-pressures from sexual health clinics (GUM services) continue to grow, with clinical activity rising year on year. This is not financially sustainable. It is therefore imperative to focus on ensuring sexual health services become more cost effective and on channelling resources into prevention in order to drive clinical costs down whilst improving health outcomes.

Prevention
Currently, the largest proportion of funding is spent on clinical services. There is a need for greater investment in prevention to reduce the need for clinical services, thereby delivering cost savings and better health. We will shift investment into evidence-based prevention, and embed it into all services. We will build on existing evidence and NICE guidance to commission or re-commission new prevention initiatives

and lead a new 3-year programme of HIV prevention for London, complementary to local initiatives. Locally, we will work collaboratively with substance misuse commissioning to maximise shared intervention opportunities. We will coordinate with prevention commissioned at London and national levels.

Reshaping of services

Reshaping provision of services (sexual health promotion, integrated sexual health clinics and HIV care and support services) is a priority in order to ensure that they meet the needs of our diverse population. Key to this is identifying optimum location of sites, consolidating resources, and shifting non-complex activity to self-management, pharmacy and primary care. Sexual health services will focus on: complex cases; outreach to vulnerable groups; clinical governance for the whole system; Patient Group Directions (PGDs) and training. We will continue to contract primary care for sexual health services, working with CCGs to develop and monitor sexual health LES.

We also recognise the importance of supporting innovation and making best use of new technologies to improve our sexual health services and ensure best value. We will support the development of SH24, a virtual, holistic, sexual health service linked to specialist services that aims to provide an online sexual health service available 24/7 at home or 'on the go'.

We will work towards a re-balance of specialist & mainstream support for people living with HIV and ensure on-going evaluation of care & support services. We will explore a range of alternative delivery models. We will promote HIV testing, working with partners to ensure opportunities for HIV testing in acute and community settings are maximised whilst also exploring options for home sampling and testing for high risk groups.

There is a need to further modernise psychosexual services to create seamless pathways that make best use of capacity and skills.

Termination of pregnancy

There are high rates of termination of pregnancy in LSL. We will prioritise reducing repeat terminations. We will work with providers to broaden approaches that focus on the wider determinants of health, for example, where possible, introducing alcohol brief interventions. We will also, conduct research into ward level analysis in relation to repeat terminations.

Teenage pregnancy and young people

Under-18 conception rates in Southwark and Lambeth, although high, have been falling. In Lewisham the rate is rising. It is important that the reduction of under-18 conceptions remains a priority across LSL, and we will work with health and youth services and Teenage Pregnancy Co-ordinators across LSL to ensure this. We will focus particularly on young people under 16. We will continue to improve access to Long Acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC) through extending primary care and pharmacy provision. We will work with faith communities to deliver information about teenage pregnancy.

STI infection rates amongst young people are high. We will maintain or increase Chlamydia diagnosis and screening, and prioritise Chlamydia prevention. We will continue to support the GP champion role, which has proved valuable in developments such as Chlamydia screening.

Safeguarding young people is central to our strategy and the services we commission. Only by reaching out to the most vulnerable young people will we improve their sexual health in LSL. We will explore options for developing a pilot focused on women and girls experiencing violence.

We will review the WUSH strategy, and strengthen work in schools and in youth settings. We will introduce an LSL-wide condom distribution scheme and GP scheme.

We will ensure all staff are competent to support new delivery models, to make every contact count and to improve the service user's journey and experience.

1. Introduction

1.1 Background

Sexual health is an important public health priority, at both national and local levels. The London boroughs of Lambeth, Southwark and Lewisham (LSL) have the highest rates of sexually transmitted infections, HIV and teenage conception rates in London and the UK. Sexual health and wellness is a complex issue, with many social, economic and cultural factors linked to it. Improving and developing local sexual health services, and making sure that people know how to access them and what they offer, can result in better sexual health in our residents and economic savings in treatment. Improving health and wellness across LSL is a complex challenge that will require a clear strategic commissioning approach, based on the best evidence and strong stakeholder and user engagement.

Following the Health and Social Care Act 2012, Public Health responsibilities were transferred to Local Authorities. Since 1st April 2013,LSL have been responsible for commissioning most sexual health services and interventions. Other elements of sexual health service provision are commissioned by Clinical Commissioning Groups (CCG) or by NHS England, as outlined below.

Local Authorities commission:

- Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)
- Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
- Sexual health aspects of psychosexual counselling
- Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies
- Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:
    - HIV social care
    - Wider support for teenage parents

Clinical commissioning groups commission:

- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see "NHS England commissions")
- Female sterilisation
- Vasectomy (male sterilisation)
- Non-sexual health elements of psychosexual health services
- Contraception primarily for gynaecological (non-contraceptive) purposes
- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments

NHS England commissions:

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

LSL have taken a joint approach to commissioning sexual health services within a tri-borough agreement. Lambeth Council hosts the tri-borough sexual health commissioning team. The transfer of responsibility to the Local Authorities for commissioning, combined with this tri-borough approach, provides opportunities to achieve better outcomes and value for money in two main ways:

- Some groups of people are statistically more vulnerable to having poor sexual health including people with problematic substance use, homeless people and vulnerable young people. Commissioning from within the Local Authority gives us better opportunities to link with the commissioners for these other health and social issues, so that people who are more likely to have poor sexual health can receive more targeted information and support.
- Commissioning across the three areas means we can offer a choice of services and achieve better value for the money we have to spend.

Since 2013 Lambeth Council has also hosted the scaled down Pan London HIV Prevention Programme. Local funds, released from the programme, have enabled investment in an additional commissioning post with a sole focus on prevention. LSL have tried to prevent the fragmentation of sexual health commissioning by ensuring that Local Authority and CCG commissioning is collaborative and integrated. One of the ways in which this is done is that the Local Authority based sexual health commissioning team provides strategic commissioning oversight for HIV care and support, termination of pregnancy and vasectomy on behalf of Lambeth, Southwark and Lewisham CCGs. It also commissions prevention, health promotion and open access sexual and reproductive health clinical services, on behalf of the three local authorities.

1.2 Purpose of the strategy

This tri-borough strategy sets out the strategic priorities for the improvement of the sexual health of residents of the London boroughs of LSL, and explains on what evidence these priorities have been decided. In order to do this, it provides an overview of the range of locally commissioned sexual health services and identifies the gaps in sexual health provision and how these translate into local sexual health priorities.

It builds on previous work, including local sexual health strategies, the Sexual Health Modernisation Initiative programme and the South East London Sexual Health and HIV Network. It has been developed through engagement with our partners and is informed by their views. Our key partners are:

- Lambeth, Southwark and Lewisham Clinical Commissioning Groups
- Lambeth, Southwark and Lewisham Local Authorities
- Acute NHS Trusts
- Community, primary care and third sector providers
- Service users

1.3 Definitions of sexual health and prevention

The World Health Organization (1975) defines sexual health as:
"*A state of physical, emotional, mental and social well being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*

Prevention can be defined as:
'Actions directed to preventing illness and promoting health to reduce the need for secondary or tertiary health care' (Mosby, 2009).

There are three tiers to prevention: primary, secondary and tertiary. These are explained in Table 1 below, with examples for activities relating to HIV and sexual health:

Table 1: Definition and overview of the 3 levels of prevention

	Definition
Primary Prevention	Prevention of disease through the control of exposure to risk factors (eg*"not getting HIV in the first place")* Traditionally most population-based health promotion activities are primary preventive measures Examples: provision of free condoms; behaviour change
Secondary Prevention	The application of available measures to detect early departures from health and to introduce appropriate treatment and interventions *(eg "getting tested regularly and if you test positive getting on treatment to prevent it damaging your immune system and reduce the risk of passing it on")* Examples: promoting demand and increasing supply of HIV testing, in order to diagnose early and thus reduce morbidity and mortality (individual health benefit), whilst limiting onward transmission through reduced infectivity (prevention benefits of anti-retroviral medications)
Tertiary Prevention	The application of measures to reduce or eliminate long-term impairments and disabilities *("making sure you get the care and support needed to ensure living with HIV as a long-term condition doesn't cause extra problems for your health and wellbeing")* Examples: ART access; clinical HIV LTC management; self-management; effective social and emotional support services; some type of "positive prevention"; sexual health promotion with diagnosed patients

Sources: Steinberg, P. (2011) House of Lords submission for HIV in the UK

1.4 Vision

Our vision is to improve sexual health in Lambeth, Southwark and Lewisham by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities. These will provide a comprehensive and efficient range of dynamic and needs-led services that work in synergy with those diverse populations, targeting the most vulnerable and at-risk. They will be driven by innovation, collaboration and partnership work, ensuring that we create world class sexual health services in an area of high need that will promote overall positive sexual health and well-being in our communities.

1.5 Principles

The strategy enshrines some key principles as follows:

- Recognising prevention of sexual ill health and unplanned pregnancy as key local priorities that affect the health and wellbeing of residents
- Targeting resources in order to meet the needs of those who are most at-risk or experience barriers to accessing information and services including: young people; men who have sex with men (MSM); [1]black and minority ethnic (BME) communities
- Involving service users in all aspects of the strategy development, implementation (for example, involving service users in procurement processes) and review
- Ensuring meaningful service choice, accessibility and confidentiality through effective commissioning and service information
- Utilising technology to improve and reshape services, including the prioritisation of self-management (where appropriate)
- Building in regular service evaluation and strategic review to align with emerging needs
- Making every contact count in the services we commission
- Sharing learning from all we do across Lambeth, Southwark and Lewisham

1.6 Aims

We will work towards our strategic vision by delivering on the following aims:

- Embedding good sexual health and wellness as part of a wider health agenda
- Actively promoting good sexual health, not just the absence of disease and delivering better prevention
- Reducing the stigma attached to sexually transmitted infections and sexual health
- Focusing on those statistically most at risk of poor sexual health thereby reducing health inequalities
- Reducing the rates of unplanned pregnancy and repeat terminations, especially for under 18 year old conceptions
- Reducing rates of undiagnosed sexually transmitted infections and HIV
- Aligning strategic priorities with the intentions of our local CCGs, other Council strategies and Joint Health and Wellbeing Strategies to ensure commissioning and provision of a comprehensive range of world class, cost effective, integrated sexual health services ranging from self -management to complex and specialist care
- Developing the workforce to deliver integrated and improved services
- Commissioning to improve cost-effectiveness and outcomes

1 The term MSM is adopted within this Strategy given the focus on sexual behaviour in the context of sexual health promotion. It is also used for purposes of concision

1.7 Scope

The strategy covers the next 3 years, 2014-2017, and will have a tri-borough approach drawing out borough differences where appropriate and including an outcome based commissioning plan. Progress will be regularly reviewed and assessed by the LSL Programme board to ensure that it remains fit for purpose. The scope may be influenced by changes in government and national policy.

Outside of the scope of the strategy are services for sexual assault referrals and HIV treatment services, which are the responsibility of NHS England. The Health and Social Care Act 2012 gives CCGs a statutory duty to assist and support NHS England to secure continuous improvement in the quality of primary medical services.

1.8 Sexual health challenges – the national picture

In 2012 there were an estimated 98,400 (93,500-104,300) people living with HIV in the UK. Almost a third (30%) of people newly diagnosed with HIV were born in the UK. For those diagnosed in 2011 and 2012, the most common route of acquiring HIV was through sex between men (54% of new diagnoses). Sex between men and women was the second most common route of infection accounting for 1,130 (43%) of new diagnoses in London (down from 59% in 2003). As such, HIV prevalence is highest amongst MSM. There are, however, other key groups that are statistically more at risk of HIV infection, in particular black African and Caribbean populations, people who inject drugs and sex workers. Almost three quarters of those diagnosed with HIV in 2011 were male (74%). The number of new diagnoses of HIV is higher among people from more deprived areas, and there are more cases amongst MSM, BME and in people who have been exposed to HIV whilst abroad.

Overall, MSM have some of the highest rates of sexual ill health. Data suggests that 51% of cases of HIV were acquired through sex between men, and new diagnoses in MSM have risen year on year since 2007. It also shows that 54% of men with syphilis and 24% of men with gonorrhoea had had sex with other men (Health Protection Agency, 2004). However, in heterosexually acquired cases of HIV, it was females who had the highest infection rates (58%). Almost one third of heterosexually acquired cases of HIV in the UK in 2011 (31% n=317 adjusted) were probably infected in the UK. An estimated 21,900 people living with HIV were unaware of their infection in 2012[2].

Young people under the age of 25 years experience the highest STI rates, making up64% of Chlamydia and 54% of genital warts diagnoses in heterosexuals[3]. New gonorrhoea diagnoses rose 21% overall and by 37% in the MSM population. Over 1.7 million Chlamydia tests were undertaken and over 136,000 diagnoses were made in 2012. High gonorrhoea transmission rates are contributing to the growing global threat of antibiotic resistant gonorrhoea[4]. A national public health priority will be to ensure that treatment resistant strains of gonorrhoea do not persist and spread, along with its complications.

Ethnicity has an effect on the level of risk of poor sexual health between particular groups of people. For example, there is a higher prevalence of STIs among African and Caribbean communities and a lower prevalence among Asian communities, when compared with the white British population (Shahmanesh et al., 2000; Low et al, 2001).

2HIV in the United Kingdom: 2013 report Public Health England :November 2013

3Sexually transmitted infections and Chlamydia screening in England, 2012. HPR 7(23), 7 June 2013: HIV/STIs (following pages).

4 Public Health England. “Gonorrhoea Resistance Action Plan for England and Wales”, February 2012.

National data also shows wide variations in the rates of abortion and conception amongst women from more deprived areas in England. The most deprived areas also have the highest overall rates of abortion for women of all ages, even when the high conception rates are considered (National Centre for Health Outcomes Development, 2006). Recent evidence has shown a trend of increased abortion in teenagers in affluent areas, compared to teenagers in deprived areas (National Centre for Health Outcomes Development, 2006b).

The rise in STIs and under 18 conception rates in England suggests that significant numbers of people (specifically young people, people from BME groups and MSM) are still engaging in risky activities. However, some of this increase in the number of STIs may be attributed to improved testing and data collection methods, rather than increased prevalence.

To address and respond to the increase in STIs and HIV, a number of national strategies and frameworks have been implemented. The most recent national strategies and guidance are shown below in Table 2.

Table 2: Recent relevant sexual health strategy and policy

White paper /Policy	Year	Key Messages
DH Healthy Lives, Healthy People	2010	Advocated the reconfiguration of the NHS, with Commissioning Board acting on behalf of Public Health England or lead by local authorities through a ring-fenced grant. Devolving functions to the local level, wherever possible, local authorities will take primary responsibility for health improvement, and take responsibility for some specific preventative services.
DH Equality and Excellence: Liberating the NHS	2010	Provided the opportunity to reshape the way in which sexual ill health in England was to be addressed. It provided the possibility to re-assess current sexual health promotion and prevention work and look at areas where it has and has not been effective. It offered the opportunity to decommission areas that had been ineffectual and to commission new evidenced-based and outcome focused services.
DH Public Health Outcomes Framework	2013-2016	Refocus on achieving positive health outcomes and reducing inequalities in health for the national population. It set out a vision to improve and protect the nation's health and wellbeing, and to improve the health of the poorest fastest. Within this document public health indicators were set. Four relate to sexual health: *-Reduction in violent crime (including sexual violence).* *-Under 25 year Chlamydia diagnostic target 2400 positives per 100,000 young persons* *-Reduction in under 18 conceptions* *-Reduction in the number of people presenting with late stage HIV.*
DH Framework for improvement of sexual health	2013	Set the ambition to: • Reduce inequalities • Build open and honest culture; informed and responsible choices • Recognise sexual ill health affects all parts of the community often when unexpected. • • This white paper's objectives were to: • Build knowledge and resilience amongst young people • Rapid access to high quality services • People remain healthy as they age • Priorities prevention • Reduce the rates of STIs amongst people of all ages • Reduce the onward transmission of HIV and avoidable deaths • Reduce unintended pregnancy amongst all women of fertile age • Continue to reduce the rates of under 16 and 18 teenage conceptions

More details of recommendations from national documents can be found in Appendix 1.

1.9 Sexual health challenges – the London picture

Sexual ill health is a major challenge in London, which had the highest number of sexually transmitted infections (STIs) recorded in England. London continues to have one of the highest

rates of teenage pregnancy in Western Europe and the highest rates of abortions and repeat abortions across all age ranges in the UK. In 2012, there were 2,832 new HIV diagnoses in London clinics, an increase of 8% from 2011 (when there were 2,637 new diagnoses). Among those born abroad, 32% were born in Africa. In 2012, 48% of all new HIV diagnoses in England occurred in London. The number of new HIV infections in London continues to rise. This increase in the number of new diagnoses reverses the downward trend seen between 2003 and 2011, which was thought to be due to changing patterns in migration.

1.10 National targets & priorities

Improved sexual health is a strategic priority at both national and local levels. A number of national public health indicators and targets are in place in order to provide oversight of sexual health improvement. Previous national and local strategies had a focus on the achievement of the following national targets:

- Reduction in under 18 conceptions
- Increases in Chlamydia screening
- Improvement in GUM 48 hour waiting times
- Improvement in % of abortions completed under 10 weeks gestation (i.e. rather than later)

LSL has made excellent progress on all of these targets and has consistently achieved the highest numbers of Chlamydia screens in the country. Teenage pregnancy rates have also seen notable reductions. Local progress toward these targets is shown in Table 8 below.

The LSL strategy will be informed by, and ensure measurable progress against, national targets and priorities.

Table 3: Local performance against national indicators and targets [5]

Objective	Measure Overall	Target	Present Position	RAG Rating
Reduce the under 18 conception rate	No of conceptions per thousand of the population aged 15-17 yrs	Reduce by 50% the under 18 conception rate by 2010 from the 1998 baseline	Lambeth:	Green
			Southwark:	Green
			Lewisham:	Red
Chlamydia diagnostic public health indicator	Rate per 100, 000 under 25 year old diagnosed Chlamydia positive as a `result of opportunistic screening	2300 per 100,000 Chlamydia positive under 25 year old	Lambeth:	Green
			Southwark:	Green
			Lewisham:	Green
Reduce rate of late HIV diagnosis	Late HIV diagnoses as an overall percentage of new HIV diagnoses	Reduce late diagnosis of HIV by 15% by 2010/2011	Lambeth:	Green
			Southwark:	Green
			Lewisham:	Red
Reduce late abortions	Percentage of Abortions performed under 10 weeks gestation as a percentage of all NHS funded abortions	70 percent of abortion performed under 10 weeks	Lambeth:	Green

[5] Sexual Health Balanced Scorecard 2010 and ONS 2013

1.11 Sexual health challenges - the local picture

1.11.1 Lambeth

There are currently 303,100 Lambeth residents. This has increased by 19,000 from 284,000 since 2001 (source: national census data 2001). Lambeth is extremely ethnically diverse- - 'the world in one borough'. It has the highest proportion in the country of:

- Portuguese born people
- South American born people
- Mixed race white and black African born people (the proportion of mixed race people has increased from 4% to 7%)
- People from multiple mixed ethnic backgrounds
- People from non-Caribbean and non-African black backgrounds

Lambeth has the second highest proportion of black Caribbean people (although this has reduced from 12% to 10%) in the country and the highest number of Rastafarians.

Lambeth is a young borough. It has the second highest proportion of single people in the country, and the second lowest proportion of married couples (although it is the 6th highest in terms of civil partnerships in the country).

The borough has the highest number of young house-sharers in the country, reflecting a change in the actual accommodation on offer in the borough (49% of properties are converted/shared flats - up from 45%) and a higher proportion of private renters (up from 18% to 28%).

1.11.2 Southwark

Southwark's population was estimated as 288,283 in the 2011 Census - an increase of 18 per cent since 2001 (against the revised 2001 Mid Year Estimate) and the latest Mid Year Estimate (2012) published on June 26th estimated the population to 293,530.

Southwark has a young population, with 58% of its population aged 35 or under. It is densely populated, with the 9th highest population density in England and Wales at 9,988 residents per square kilometre.

Southwark is ethnically diverse. The borough has the highest proportion of residents born in Africa in the country (12.9%), as well as significant populations from Latin America, the Middle East, South East Asia and China. Seventy five per cent of reception-age children are from BME groups. Over 120 languages are spoken in Southwark. In 11% of households nobody has English as a first language.

Southwark has high levels of inequality. The median income of council tenants (which make up 31.2% of all households) is £9,100, which is five times less than the median income of homeowners in the borough.

1.11.3 Lewisham

Lewisham's population of about 284,000 people is relatively young, with one in four residents aged under 19 years. The population aged 60 years and over represents one in eight people in the borough. This contrasts with England as a whole, where between one in four and one in five people is over 60 years old.

Males comprise 49% of Lewisham's population, females 51%. These proportions are not expected to change in the next few years.

Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a Black and Minority Ethnic background. The largest BME groups are black African and black Caribbean. In total, black ethnic groups are estimated to make up 30% of the population of Lewisham.

There are no accurate statistics available regarding the profile of the lesbian, gay, bisexual and transgender (LGBT) population either in Lewisham, London or Britain as a whole. Sexuality is not incorporated into the census or most other official statistics. The Greater London Authority based its Sexual Orientation Equality Scheme on an estimate that the lesbian and gay population comprise roughly 10% of the total population. This would make the lesbian and gay population of each borough roughly 30,000, although whether this includes bisexual or transgender individuals is unclear. About 0.4% of Lewisham households comprise same sex couples in civil partnerships (Census 2011). This is more than double the average for England.

1.11.4 Across Lambeth, Southwark and Lewisham

The LSL populations are young and ethnically diverse. Lambeth and Southwark have the highest estimated concentration of MSM population in London and in UK. The MSM population is estimated at 15% of the total population. All three boroughs have high concentrations of people from BME groups.

The demography of LSL explains some of the poor sexual health across the three boroughs. Some population groups have higher levels of sexual health risk and need, and more likelihood of experiencing barriers to accessing prevention, testing and treatment than the general population. These groups, concentrated in all three boroughs, are:

- Young people
- Migrants from countries with relatively high HIV prevalence
- MSM
- Homeless people
- Refugees and asylum seekers
- People who experience domestic violence

Poor sexual and reproductive health is associated with individual risk taking behaviours among 15-59 years old population as well as socioeconomic determinants. Nationally the following groups have been shown to have higher rates of acute STIs: young people (15-24 years); MSM (for syphilis and gonorrhoea) and black Caribbean ethnic groups. Amongst MSM, an estimated more than 50% consume illegal drugs at some point in time (compared to an estimate of 12% in wider population), which is in itself a behaviour statistically linked to risky sexual behaviour.

Unplanned pregnancies reflect unmet needs relating to contraception. The risk of unplanned pregnancy in younger women (under 18) is associated with being the child of a teenage mother, alcohol consumption and social and economic deprivation. There is evidence from abortion statistics that an increasing number of women aged 25 years and older have unplanned and unplanned pregnancies.

GUM clinics show a strong positive correlation between rates of STI and the index of multiple deprivation across England. The relationship between STIs and socioeconomic deprivation is influenced by a range of factors such as the provision of, and access to, health services, education, health awareness, health-care seeking behaviour and sexual behaviour. Table 3 below shows population groups in LSL that are statistically at higher risk of poorer sexual health.

Table 4: Population groups at higher risk of sexual health issues- number of people

	Lambeth	Southwark	Lewisham
Total population 2011	304,000	289,000	277,000
MSM 16-44y (estimate: 15%)	12,963	12,088	10,032

15-24 y	39,429	44,311	32,712
Black African	35,187	47,413	32,025
Women in child bearing age (15-49 Y)	95,319	89,932	80,429
Living in 20% nationally most deprived	111,732	104,068	101, 46
Look after children 2013[6]	500		565
Refugees & asylum seekers			
Service users with learning disabilities (GP LD registers)	1,032	659	786
Service users with severe mental illness (GP SMI register)	4,614	3,619	3,693

1.11.5 Infections

The full report of a recent local epidemiological needs assessment is available on Lambeth, Southwark and Lewisham Councils' websites. The report provides useful information to underpin strategic decision-making. Key sexual health issues for LSL raised by the needs assessment can be summarised as follows:

1. STI rates across Lambeth, Southwark and Lewisham have continued to rise locally. This is an expected outcome of increasing access to sexual health services and improved testing methods following the Modernisation Initiative and previous sexual health strategy.
2. In 2012, Lambeth was ranked 1st out of 326 local authorities (i.e. has the highest rates) in England for acute STIs in 2012. 9,773 acute STIs were diagnosed in residents of Lambeth (a rate of 3209.7 per 100,000 residents). Southwark was ranked 3rd with 6,350 acute STIs diagnosed in residents of Southwark (a rate of 2199.4 per 100,000 residents). There have been coding errors in Lambeth and Southwark, this suggests that Lambeth and Southwark have similar STI rates. Lewisham was ranked 17thwith 4,066 acute STIs diagnosed in residents of Lewisham (a rate of 1468.2 per 100,000 residents)

Table 5: Rates of STIs and HIV in LSL residents in 2011 and 2012

STI Rates per 100,000 population	England		Lambeth		Southwark		Lewisham	
Year	2011	2012	2011	2012	2011	2012	2011	2012
Acute STI	791.2	803.7	2620.2	3209.7	2191.0	2199.4	1291.7	1468.2
Chlamydia	351.2	371.6	1031.0	1642.5	919.4	895.0	687.5	915.4
Gonorrhoea	39.0	45.9	337.8	410.5	251.5	294.4	89.3	107.6
Syphilis	5.4	5.4	73.8	70.9	42.9	53.0	15.8	17.0
Genital warts	141.6	134.6	262.9	247.3	229.6	223.4	135.8	141.2
Genital herpes	58.0	58.4	127.6	124.5	111.8	117.4	42.4	41.9

Sources: PHE LASER reports 2011 and 2012

3. Recent analysis of sexual health provision within LSL indicates that Community RSH and GUM services are doing well in supporting equitable access as reflected in the diversity of sexual health service users. Table 5details user profile.

Table 6: Sexual health service user profile

[6]http://atlas.chimat.org.uk/IAS/metadata/view/geofeature?id=_208&pid=4&norefer=true

Service	Lambeth	Southwark	Lewisham
GUM	**59% men:** • 22.3% under 25 • 66% 25-44, • 50% MSM • 58% born in UK • 7% born in Africa	**50% men** • 29 % under 25 • 61% 25-44 • 23% MSM • 55% born in UK • 12.5% born in Africa	**56% men** • 22% under 25 • 65% 25-44 • 40% MSM • 56.4% born in UK; • 10.5% in Africa
RSH	31% under 25; 49% white; 26% black; 17% men (28% in Vauxhall)		42% under 25; 22% male

4. The rate of Chlamydia diagnoses per 100,000 young people aged 15-24 years in Lambeth in 2012 was 6,131.9, which was much higher than expected. The rate of Chlamydia diagnoses per 100,000 young people aged 15-24 years in Southwark was 3,306, which was lower than would be expected and is probably due to a coding error. The rate of Chlamydia diagnoses per 100,000 young people aged 15-24yearsin Lewisham was 4178.9 in 2012. Chlamydia numbers and rates for Lambeth and Southwark should be viewed with caution due to a probable coding error and cannot be compared to previous years due to the addition of laboratory data, screening data and GUM clinic data.
5. Human Papillomavirus (HPV) diagnoses are showing a reduction in numbers nationally. Locally, the numbers have plateaued, correlating with the introduction of the HPV vaccination in schools.
6. The National Sexual Attitudes and Lifestyle survey 2011 shows that gonorrhoea infections are mainly associated with groups at higher risk in relation to poor sexual health. In LSL, diagnoses of gonorrhoea continue to be high, which is probably due to the numbers of residents from high-risk populations (primarily MSM and BME communities).
7. HIV prevalence continues to rise both nationally and locally. It is estimated that, in London, one in five people who have HIV are unaware of their diagnosis. Lambeth and Southwark have the highest prevalence of HIV in the UK. Groups most affected in LSL are Black African people and MSM.

Table 7: HIV Prevalence

HIV	London 2011	Lambeth 2011	Southwark 2011	Lewisham 2011
Numbers	31,147			
Prevalence (per 1000 15-59 year olds)	5.4	13.9	11.7	7.8
Late diagnosis %	44%	39%	45%	52%
New diagnosis (numbers)	2,637	251	214	118
Estimated undiagnosed %	1 in 5 cases of HIV	-	-	-

8. In 2011, the diagnosed HIV prevalence in Lambeth was 13.9 per 1,000 population aged 15-59 years (compared to 5.4 per 1000 in London and 2 per 1,000 in England). For Southwark and Lewisham, diagnosed HIV prevalence was 11.7 and 7.8 per 1,000 population aged 15-59 years respectively.

9. In Lambeth, between 2009 and 2011, 39% (95% CI 35-43) of HIV diagnoses were made at a late stage of infection[7] compared to 44% in London and 50% (95% CI 49-51) in England. This compares to 45% (95% CI 41-50) in Southwark and 52% (95% CI 46-57) in Lewisham.
10. The number of new HIV infections in London continues to rise. In 2012, there were 2,832 new HIV diagnoses in London clinics, an increase of 8% from 2011, when there were 2,637 new diagnoses. This increase in the number of new diagnoses reverses the downward trend seen between 2003 and 2011, which was thought to be due to changing patterns in migration. New diagnoses in men who have sex with men have risen year on year since 2007. In 2012, 48% of all new HIV diagnoses in England occurred in London. Almost a third (30%) of people newly diagnosed with HIV in 2012 were born in the UK (where country of birth was reported). Among those born abroad, 32% were born in Africa.
11. Almost three quarters of those diagnosed with HIV in 2011 were male (74%). However, in heterosexually acquired cases, it was females who predominated (58%). Almost one third of heterosexually acquired cases in 2011 (31% n=317 adjusted) were probably infected in the UK. This is higher than in 2010 (29%), but numbers are lower (n=335). The 2011 figure is almost double the number of heterosexuals infected in the UK in 2002. The most common route of acquiring HIV in those diagnosed in 2011 and 2012 was through sex between men (54% of new diagnoses). Sex between men and women was the second most common route of infection accounting for 1,130 (43%) of new diagnoses in London; this is down from 59% in 2003. As such, HIV prevalence is highest among men who have sex with men (MSM). However there are other key at-risk groups for HIV, in particular black African and Caribbean populations, as well as people who inject drugs and sex workers.
12. Over the last few years there have been a number of outbreaks of infections in MSM. These include Hepatitis A, shigella and LGV. More detailed research has shown that some infections are related to high risk sexual activity associated with substance use. The research has shown that many of these men have concomitant STIs, HIV and other infections e.g Hepatitis C. There has been a national response recently to shigella outbreaks, which we will draw on locally. Other outbreaks in future will have a rapid response via locally re-commissioned prevention and health promotion services
13. Young people have the highest rates of Chlamydia. In 2012, of the three boroughs, Lewisham had the highest percentage of diagnoses of acute STIs in young people aged 15-24 years (48%) followed by Southwark (38%) and Lambeth (35%).

1.11.6 Conceptions

Lambeth, Southwark and Lewisham have high conception rates relative to London and England. Between 2009-2011 conception rates were highest in Lewisham, followed by Southwark and then Lambeth. The biggest difference in fertility within a borough (ie. between wards) is found in Southwark. Under 18 conception rates over the same period are not statistically different between the 3 boroughs. All 3 boroughs have relatively high teenage pregnancy rates. However, these have fallen significantly over the last 15 years.

2012 Under 18 conception numbers and rates have recently been published (February 2014). This data shows a continued reduction in teenage conceptions in both Lambeth and Southwark. Table 1 shows how all three boroughs have shown dramatic reductions in teenage conception rates over the last fifteen years.

For Lambeth, the under 18 conception rate (15-17 years old) has reduced by 65.4% from its highest in 2003 and 61.1% from the 1998 baseline to 33.2 /1000 girls aged 15-17 in 2012. In 13-15 year olds, the rate has dropped by 23.5% to 7.8/1000 and 75% of these end in abortion.

[7] i.e. with a CD4count<350cells/mm3within3monthsofdiagnosis

In Southwark, the under 18 conception rate has reduced by 63.5% since the 1998 baseline to 31.8/1000 15-17 year olds. In 13-15 year olds, the rate has dropped by 41.1% since 2008-2010 to 7.6/1000 and 72.6% of these end in abortion.

In Lewisham, the under 18 conception rate has reduced by 47.5% since the 1998 baseline to 42/1,000 15-17 year olds. This represents a slight increase on the 2011 rate which was 39.9/1000. Under 16 conception rates in Lewisham are lower than Lambeth and Southwark at 6.9 per 1,000. However, a smaller proportion of them end in abortion, 58.9% compared to over 70% in Lambeth and Southwark.

Table 8: Performance Against Statistical Neighbours for under 18 conception rates.

LA	1998		2012		Change
Inner London	Number	Rate	Number	Rate	1998-2012
Tower Hamlets	222	**57.8**	93	**24.3**	**-58.0**
Hackney and City of London	273	**77.1**	118	**28.8**	**-62.6**
Newham	296	**59.9**	145	**24.1**	**-59.8**
Haringey	227	**62.3**	142	**33.1**	**-46.9**
Lewisham	319	**80.0**	197	**42.0**	**-47.5**
Lambeth	365	**85.3**	142	**33.2**	**-61.1**
Southwark	318	**87.2**	134	**31.8**	**-63.5**

Figure 2: Under 18 conception rate per 1,000 females aged 15-17, 1998-2012

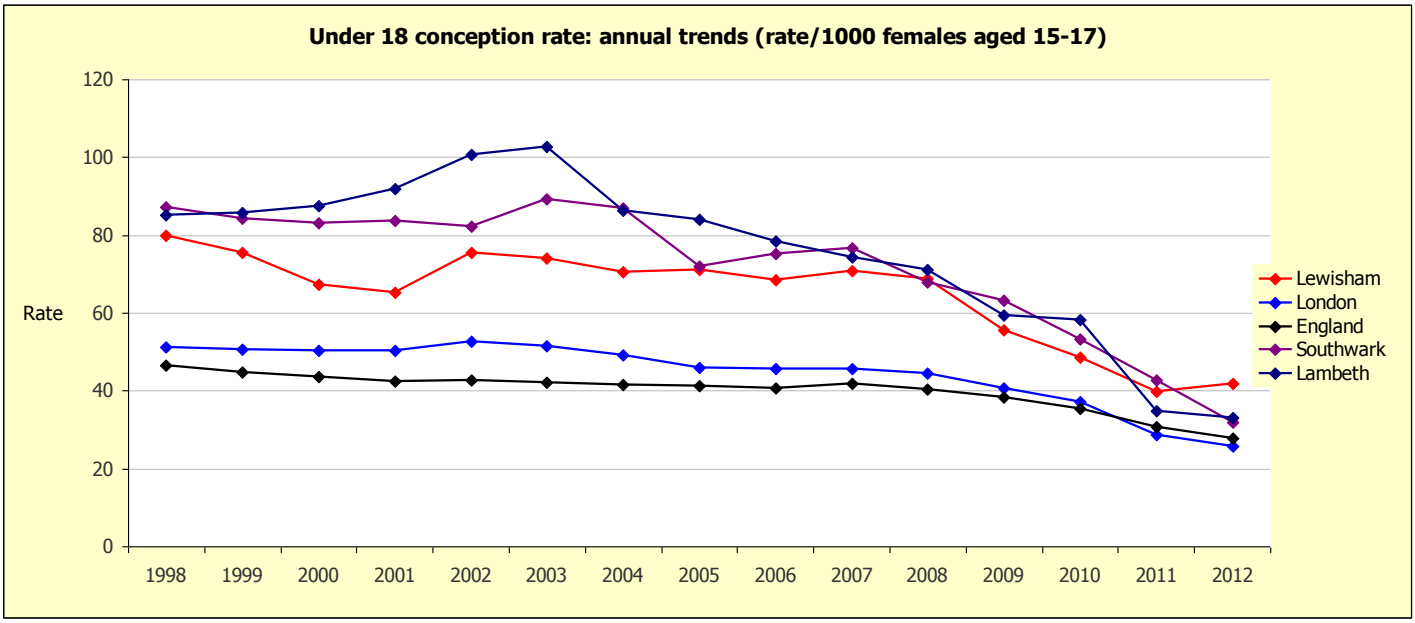


Table 9:Teenage Pregnancy rates 2012

Conception Rates / % of abortions	London	Lambeth	Southwark	Lewisham
Under 16 conceptions per 1000 persons (2010-12)	5.5	7.8	7.6	6.9
15-17 Conceptions per 1,000 in girls aged 15-17 (2012)	25.9	**33.2**	**31.8**	42.0
% under 18 yr conceptions ending in abortion	62.2%	64.8%	63.4%	61.4%

% of under 16 yr conceptions ending in abortion	-	75.0%	72.6%	58.9%

Source: ONS 2014

1.11.7 Abortions

All three boroughs have high abortion rates relative to England and London. There was a plateau in the rates in 2011, but they appear to have reduced further in 2012. In 2012 Lewisham had the second highest abortion rate in London. For under 18s it had the highest rate in London, significantly higher than Lambeth and Southwark. The highest rate was in Camberwell Green ward in Southwark. Rates were also high in Coldharbour ward in Lambeth, Brunswick Park, Faraday, Peckham, and Livesey wards in Southwark, and Bellingham and Rushey Green wards in Lewisham.

Table 10: Abortion Rates 2012

Abortion Rates	London	Lambeth	Southwark	Lewisham
Number		2,066	2,144	1,893
Rate (15-44yrs)	22.4	24.7	25.7	27.4
Under 18 rate	15	19	19	26
Repeat abortions (%) all ages	37	44	46	47

1.11.8 Repeat Terminations

All three boroughs have high rates of repeat termination. Repeat abortion rates are highest in Lewisham (47%), followed by Southwark (46%) and Lambeth (44%). This compares to 37% in London. In women under 25 years old, 37% in Lewisham and 33% in Lambeth and Southwark attended for a repeat abortion in 2012. This compares to 27% in London. The map below shows repeat abortions by electoral ward. The highest rate was in Camberwell Green ward in Southwark. Rates were also high in Tulse Hill and Coldharbour wards in Southwark, Brunswick Park, Peckham, and South Bermondsey ward in Southwark, and Rushey Green ward in Lewisham.

1.10.9 Ethnicity and abortion

There appears to be considerable variation in abortion rates by ethnic group. An analysis of abortions performed by local providers between 2008 and 2013 (excluding privately funded abortions) shows that the rates are much higher in the Black and 'other' ethnic groups. The reasons for this are not currently well understood and may relate to barriers to accessing contraceptive services. These may include: a lack of awareness of contraceptive methods available; cultural acceptability of the available methods; logistical issues such as location and opening times; and language barriers.

1.11.10 Summary

The priority groups for our work in LSL are

- MSM
- Black African communities
- Young people

We also know that other groups within the LSL population are vulnerable to poor sexual health and will also be the subject of targeted interventions. These are:

- People with mental health difficulties
- People with learning disabilities
- Lesbian, gay, bisexual and transgender people

- Sex workers
- Injecting drug users
- Homeless people
- Prisoners
- Asylum seekers
- Older people

Sexual health needs are not evenly spread across the three boroughs. Thus we will adopt a granular approach, addressing need on a highly localised basis, for example, at ward level, to target specific needs and communities.

Key messages from the needs assessment
STI rates are high and continue to rise, particularly amongst MSM, young people and Black ethnic populations.
HIV prevalence is high, with rates amongst MSM continuing to rise.
Under-18 conception rates in Southwark and Lambeth, although high, have been falling.
Under-18 conception rate in Lewisham has risen in the last year.
Termination of pregnancy rates are high, with particular concern focused on repeat terminations.
The priority groups for our work in LSL are: • MSM • Black Ethnic populations • Young people
Other new and emerging vulnerable groups will require targeted interventions.

2.Previous LSL strategies

2.1 Previously, each of the boroughs of LSL have developed their own sexual health strategies: Lambeth (2006-2010); Southwark (2006-2009): and Lewisham (2008-2011). They have been reviewed against their original aims, outcomes and gaps, in order to inform this strategy.

The aims across the previous Lambeth and Southwark strategies were:

- Reduction in health inequalities through improvements in information and services developed in partnership with Lambeth and Southwark Modernisation Initiative.
- Stabilisation and eventual reduction in STIs and teenage conception rates in Lambeth.
- Progress to achieving national regional and local targets and indicators, through service investment and re-design and investment in services.
- Developing person-centred services that are non-stigmatising and empower people to manage their own sexual health.

The aims of the previous Lewisham strategy were:

- Increase in life expectancy
- Reduction in health inequalities, in particular addressing the needs of the population groups who are at highest risk of sexual ill health
- A greater emphasis on prevention and health promotion.
- Reduction in prevalence of undiagnosed HIV and STIs
- Provision of a comprehensive network of services across the whole pathway.
- Reduction of stigma associated with HIV and STIs.
- Provision of accessible services and care, closer to people's homes.

Despite the progress some key challenges, for example, integrating sexual health services, remain which are picked up in this strategy.

3. Financial resources

3.1 Over the last few years NHS and local authority services budgets have consistently had to find cost efficiencies, whilst demand for services has grown. Although public health budgets transferring to local authorities have been ring fenced for at least two years from April 2013, it is imperative given the current climate that all sexual health services are cost effective and deliver measurable outcomes. In order to achieve this the LSL sexual health commissioning team will work with local partners to avoid duplication and to commission and deliver high quality, evidence based, needs led, responsive sexual health services.

3.2 Whilst local authority budgets have been significantly reduced, public health budgets have an element of growth allocated for 2013/14. This growth, however, is consumed by spend resulting from over-performance within sexual health clinics (GUM services), activity being paid for on the basis of payments by results (PbR), which is not sustainable in the long term. Furthermore, it has resulted in a reduction in resources available for prevention and health promotion. Neither PbR nor block contracting, which is currently the main mechanism for paying for Reproductive and Sexual Health (RSH) services, appear to be satisfactory for commissioning services in the long term, particularly for the planned integrated GUM/RSH services. Since 2008, work has taken place to deliver a London-wide integrated sexual health tariff and initial indications are that this may be the optimum way forward for paying for sexual health services. Along with other London commissioners, LSL will examine the options and benefits of adopting an integrated tariff. This system would have to be considered carefully and, if adopted, operate within an agreed system that will take account of changing costs[8]. The LSL Sexual Health Board will also consider setting targets for switching funding into preventative services.

3.3 Respective budget allocations 2013/14

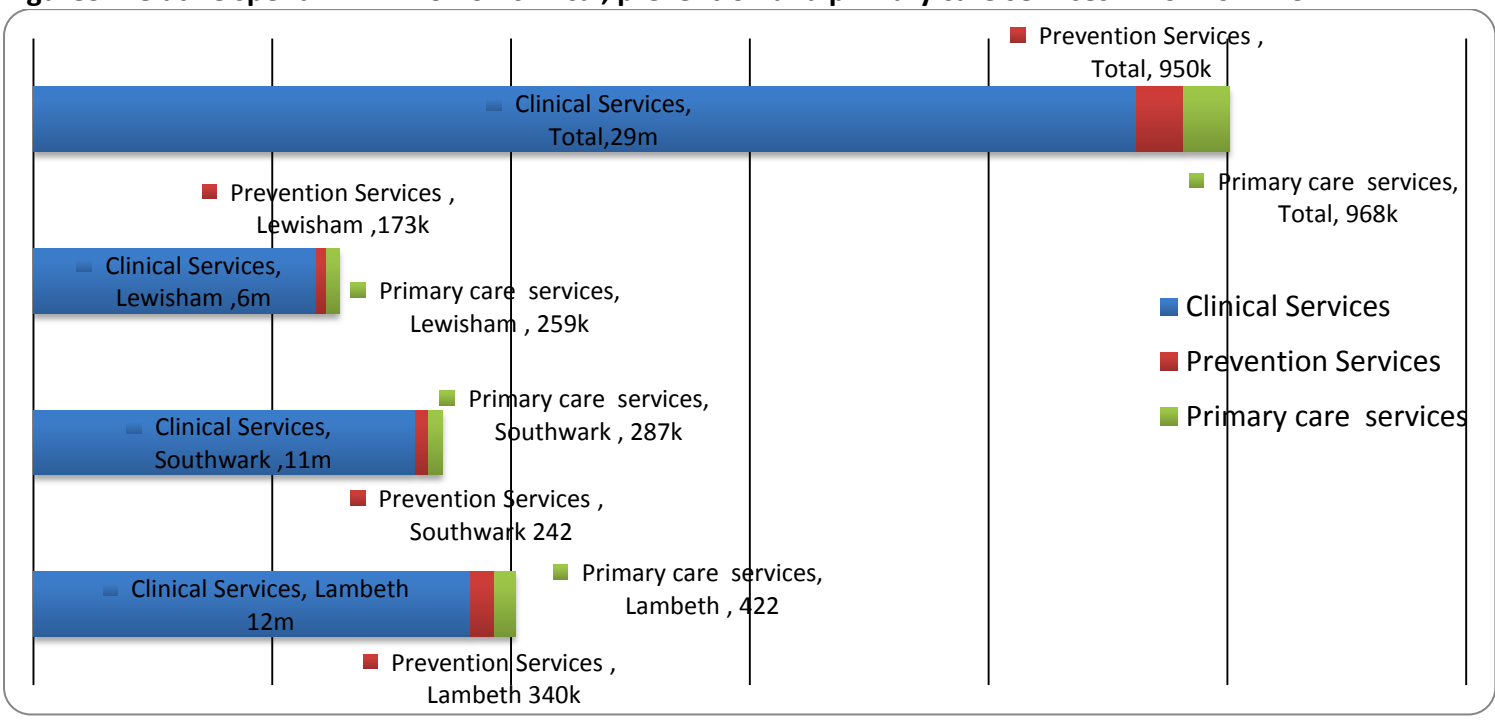
Appendix 2 shows the respective 2013/14 sexual health budgets for the LSL boroughs and highlights a variance in investment across boroughs and across prevention and treatment/care.

Lambeth has the highest level of sexual ill health across the three boroughs which is reflected in funding allocation. Lambeth's sexual health budget for clinical services was £12,030, 257 compared to Southwark's at £10,881,077 and Lewisham's at £6,256,672 .

There is a difference in the investment levels for the three boroughs between prevention (total for LSL is £754,272, not including condom distribution scheme capped funding) and clinical services (total for LSL is £29,168,006). This lower level of investment in prevention is misaligned with the strategic focus of the current strategy, which is to promote sexual wellbeing and prevent sexual ill health. Taking into account need, Lambeth spent more on prevention (£339,683) than Southwark (£241,883) and Lewisham (£172,706). This difference in spend is also reflected in primary care where Lambeth allocation (£422,265) is almost double that of Southwark (£287,055) and Lewisham (£259,157). There are specifically commissioned sexual health services within some GP practices in the boroughs, whilst sexual health falls within the overall primary care remit (and some surgeries offer additional sexual health services according to their staff specialties). Direct spend on HIV prevention and sexual health promotion, however, is a small proportion compared to that spent on clinical services, as Figure 3. below illustrates:

[8] e.g. reductions in staff costs as skill mix changes, increases in prescribing costs

Figure3: Relative spend in £million on clinical, prevention and primary care services in LSL 2012-13



Both Lambeth (£264,921) and Southwark (£276,419) fund Brook to provide a young person specific sexual health service and GSTT to provide Wise Up to Sexual Health (WUSH) (Lambeth - £261,635.00 and Southwark £ 78,000.00 contributions), a sexual health service for vulnerable young people. Despite Lewisham's relatively young population, there are no specific locally commissioned young people services in the borough.

The LSL CCG funding for sexual health services commissioned by Lambeth Council is shown in Appendix 3. Lambeth has the highest overall cost for both termination of pregnancy (TOP)/vasectomy services and HIV care/support (£ 3,067,151) compared to Southwark (£1,870929) and Lewisham (£1,880,674).

Nevertheless, Lewisham has the highest spend with Kings College Hospital for TOPs and vasectomies via BPAS, £296,000 and £ 11,718 respectively, compared to Lambeth (£229,000) As a result of historical commissioning arrangements, Southwark CCG pay £15,000 for the central booking service that covers all of LSL.

The health economics argument for greater investment in sexual health services to prevent, for example, unintended pregnancy and abortion, both of which result in greater costs downstream for health and social care services, illustrates that prevention is better than cure. For example:

- Preventing unplanned pregnancy through NHS contraception services has been estimated to save the NHS over £2.5 billion a year.
- Preventing STIs such as Chlamydia dramatically reduces the costs associated with pelvic inflammatory disease and preventable infertility.
- Increased access for women of reproductive age to long acting reversible contraception (LARC, e.g. intrauterine devices, injectable contraceptives and implants) and prompt access to emergency contraception has been proven to be cost effective.
- Increasing the number of less complex and cheaper medical abortions over surgical abortions could reduce waiting times, produce a better experience for service users, increase local access and drive down costs.

- The average lifetime treatment cost for an HIV positive individual is calculated at approximately £276,000. The monetary value of preventing a single onward transmission is estimated to be between £0.5 and £1million in terms of individual health benefits and treatment costs.

Key message
Currently, the largest proportion of funding is spent on clinical services. There is a need for greater investment in prevention to reduce the need for clinical services, delivering cost savings for health and social care services and better health for all.

It is notable that the current financial frameworks for RSH and GUM present challenges to both provider and commissioner: RSH services are block contracted, and the GUM services commissioned through activity-based PbR. The challenges are particularly problematic where there is an integrated service (see 5.3 below). There is a clear need to explore alternative approaches to contracting for services with providers, whilst aiming to contain costs.

What we will do
We will explore a range of alternative service models, including online services and other technical innovations.
We will aim to shift investment into evidence-based prevention, given the downstream savings that will be delivered in health and social care services.
We will examine options for streamlining and rationalising contracting mechanisms with GUM and RSH providers, including an analysis of the issues and potential benefits or otherwise of adopting a London-wide integrated tariff for funding sexual health services.
We will assess the type of sexual health service provision required from general practice and pharmacy and carry out a cost benefit analysis to ascertain the balance of services to be delivered in different settings.

4. Sexual health services in LSL[9]

4.1 Sexual health promotion

Previous strategies have recognised the importance of actively promoting good sexual health and safer sex. In 2007, a number of health promotion services were commissioned to target the most at-risk groups in our communities. These include Black African communities (the SAFER Partnership and African Health Forum), young people (school-based and youth work, in partnership with Teenage Pregnancy programmes) and MSM (the Pan London HIV Prevention Programme). A local NHS sexual health promotion team, providing specialist training, campaigns and resources in Lambeth and Southwark, has complemented this programme.

Key messages
Reshaping provision of sexual health promotion services, to ensure that they meet the needs of our diverse population, is a priority.

What we will do
We will reprioritise and reshape the commissioning of sexual health promotion and HIV prevention as an underlying principle of all services, including those that provide screening, treatment and care.
We will commission modernised, evidence-based sexual health promotion and HIV prevention services that seek to change behaviour and reduce risk-taking activity particularly amongst MSM, BME communities and vulnerable young people
We will work collaboratively to maintain and expand the provision of prevention approaches within non-sexual health settings, such as drugs and alcohol services, hostels and other settings with populations who have high levels of sexual health need.

4.2 HIV prevention

London local authorities account for 18 out of the 20 local authorities with the highest diagnosed prevalence rate of HIV in the country. The epicentre of this epidemic is in Lambeth, with the highest prevalence of diagnosed HIV in the UK (13.9 per 1,000 adults aged 15-59). Southwark has the second highest prevalence (11.7 per 1,000) and Lewisham has a lower prevalence (7.8 per 1,000). Our strategy will build on and complement the newly commissioned services that will form the London-wide HIV prevention programme 2014-17.

4.2.1 HIV prevention: expanding testing

Due to the effectiveness of antiretroviral drug treatments, most people with an HIV diagnosis can expect a near normal life expectancy, if diagnosed promptly and they enter into the established HIV care pathway. The costs associated with HIV treatment are high (see above), and are growing, as life expectancy for people with HIV (PLHIV) extends and as greater numbers of people are diagnosed with the infection.

Much progress has been made in recent years in changing attitudes to HIV testing. National testing guidelines for the UK were issued in 2008[10] and endorsed by the National Institute of Clinical Excellence (NICE) in 2011[11]. This guidance recommends that expanded HIV testing be

[9] See Appendix 3 for overview of sexual health services in Lambeth, Southwark and Lewisham

[10] BHIVA, BASHH, BIS. UK National Guidelines for HIV testing, 2008

[11] NICE. Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men, 2011.

conducted in areas of high HIV prevalence defined as >=2/1000 persons aged 15-59[12]. As boroughs with HIV prevalence far above this threshold, we will continue to focus resources on increasing access to HIV testing.

Evidence indicates that minimum standards for efficient and acceptable HIV testing include:

- Community engagement and involvement
- Planning services – assessing local need
- Planning services – developing a strategy and commissioning services in areas of identified need
- Promoting HIV testing for black African communities
- Reducing barriers to HIV testing for black African communities
- Healthcare settings: offering and recommending an HIV test
- HIV referral pathways.

What we will do
We will make every contact count by expanding HIV testing into wider community settings. This will include pharmacies, health checks and other non-clinical settings (particularly those targeted at key at-risk groups), and will enable us to diagnose HIV early, link patients to treatment and care, and reach those who do not use traditional NHS sexual health services.
We will work with CCG partners to ensure opportunities for HIV testing in acute medical settings are maximised.
We will examine the cost benefits of promoting and providing home sampling and home testing kits to at-risk groups.
We will increase awareness of the availability of HIV testing, de-stigmatise the process of testing, and promote the benefits of testing/treatment for people if diagnosed with HIV, as a critical component of HIV prevention in London. This will mean reshaping current HIV Prevention and Health Promotion services.

4.2.2 HIV prevention: reducing risky behaviour

In order to prevent onward transmission of HIV, testing strategies must be accompanied by behavioural interventions. The purpose of these must be to:

- Change behaviour, prevent or reduce harm arising from sexual activity and minimise the risk of infection or ill health.
- Promote the uptake and benefits of testing and screening.
- Signpost patients into sexual health services and understand what happens there.

There is specific concern around increasing sexual risk taking behaviours in MSM associated with recreational drug use and correlated with a rise in HIV and STI diagnoses. In LSL we have begun to address this through our work related to “chemsex”, beginning in 2013-14 with research into this emerging problem.

What we will do
We will build on the “chemsex” research and other evidence to commission new local prevention initiatives for MSM in LSL.
We will lead a new three-year programme of HIV prevention for London.
We will ensure that the London programme complements local initiatives aimed at changing risk-taking sexual behaviour.
We will re-commission HIV prevention for Black Africans in line with NICE guidance on HIV testing and on a refreshed evidence base for population/individual interventions.

[12] BHIVA, BASHH; BIS. UK National Guidelines for HIV testing. 2008

We will extend HIV prevention through taking a more integrated approach to substance misuse and sexual health commissioning.
We will improve coordination and collaboration across the range of prevention and promotion activities commissioned at regional (London) and national (PHE) levels. We will develop links with HIV Prevention England to coordinate local plans for HIV prevention interventions.

4.2.3 What works in HIV prevention?

The London HIV Prevention Needs Assessment 2013 identified that a number of behavioural interventions intended to raise awareness of risk and result in less harmful activity are effective, including those outlined in Table 9 below:

Table 11: Effective behavioural interventions identified in London HIV Prevention Needs Assessment 2013

Adult males	Educational interventions (particularly information/knowledge)
Adult females	Educational, supportive and media interventions
MSM	Limited effectiveness for motivational interventions, Evidence for group educational prevention, media interventions and PrEP.
BME groups	Behavioural interventions including 1-to-1 and group work
PLHIV	Motivational interventions for reducing risky sexual behaviour
PwID	Opiod substance therapy and education/support interventions supportive interventions
Sex Workers	Supportive, education, media and testing/screening effective

4.2.4 The 2014-2017 London wide programme

An interim programme, envisaged to run up to nine months, will operate whilst the new programme is being designed and commissioned. The interim programme will comprise of:

- A continuation of the Pan-London condom distribution scheme for MSM;
- An outreach programme, targeted at MSM, providing service and basic sexual health information and signposting provided in all gay venues and prioritising sites of greatest need.

The new London-wide programme is due to start before the end of 2014 and will be aimed at MSM and Black Africans. The new programme will comprise of:

- A Pan- London condom distribution scheme
- An outreach programme targeted at MSM
- A media and campaign work stream

A steering group, led by Director of Public Health for Camden and Islington, will oversee implementation of the new programme and will ensure it is fully linked in with wider work across London on sexual health. The steering group will work with LSL HIV and Sexual Health Commissioning team, including the new London-wide prevention strategic role, to shape the commissioning intentions for the programme and for the three individual work streams. The development of new commissioning aims and intentions for the programme will include consultation with stakeholders and experts. LSL HIV and Sexual Health Commissioning team will oversee the procurement of the new programme.

4.3 Integrated sexual health services

4.3.1 The last ten years have seen a drive to modernise the range of sexual health and contraceptive services into 'integrated sexual health services'(services have been commonly commissioned as either GUM or Reproductive and Sexual Health(RSH) services). This was driven by the five-year sexual health modernisation initiative (2004-2009) in Lambeth and Southwark, and by local sexual health strategies and commissioning plans.

In November 2012 a level 3 GUM service was launched in Lewisham, with the intention of transitioning to a fully integrated level 3 GUM and level 3 SRH service in the community. When Lewisham and Greenwich NHS trust was created in October 2013, the SRH and GUM service at Lewisham merged with the GUM service at the Trafalgar Clinic, which is based in the Queen Elizabeth Hospital in Woolwich. Kings College Hospital provides level 3 sexual health provision and level 3 contraceptive provision. These services provide a one-stop shop for STI screening and contraception in one attendance. Outreach services are also provided to Brixton prison in Lambeth and pilot for contraceptive provision to community drug and alcohol team in Southwark. This has involved service consolidation in a number of sites, resulting in longer, consistent opening hours and the development of capacity and capability to provide basic and intermediate STI and complex contraception services. Integrated sexual health services are also popular with service users as needs are logically connected. Community sexual health services in LSL have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations**.** In 2012-13, the community sexual health services reached 8% of 15-24 years old residents in Lambeth and Southwark and black residents were twice more likely to use the service. In 2011, Southwark and Lambeth community sexual health services were brought together under one management structure into GSTT as part of its community directorate. Community services will be merged with GSTT GUM services to create an integrated service in 2014.

Challenges for continuing with the modernisation of community sexual health include:

- The need to change opening times so that services are open for longer on fewer sites as opposed to fragmented opening times on multiple sites, which is frustrating for service users and time-consuming for staff
- Service improvement to tackle waiting times and speed up processes, particularly as appointment times in integrated services tend to be longer
- Training for staff to deliver newly configured services (there are particular challenges in terms of recruiting, training and retaining dual-trained staff).
- A focus on self-management

Key messages
More cost effective services for all can be achieved by shifting more sexual health provision into primary care and community pharmacy, enabling us to increase specialist provision within community and integrated sexual health services and develop self-management options.

What we will do
We will work with providers to review clinical skill mix, to ensure the service user's journey and experience is improved.
We will work with providers to ensure their workforces are appropriately trained and standards continuously improve.
We will work with providers to consolidate sites and resources, creating fewer, more accessible sites, and shift activity to self-management, pharmacy and primary care.

We will work with providers to increase staff capacity and pilot new models of nurse led service delivery and patient pathways, in order to improve the patient journey.

4.4 Genito Urinary Medicine (GUM) Services

4.4.1 GUM services are provided by Guys and St Thomas' (GSTT), King's College Hospital and Lewisham and Greenwich NHS Trust. The Lydia Clinic at St Thomas' Hospital moved to new premises in Bankside at Burrell Street in 2012. The Lloyd Clinic at Guy's Hospital remains mainly as a nurse-led walk-in service. GUM staff are gradually being trained to provide contraceptive services to pave the way for the merger with community sexual health services.

Use of GUM services in LSL has doubled, or in the case of Southwark tripled, since 2008 (see Appendix 4). The profile of users of GUM differs between the boroughs. Of those using the GUM and resident in Lambeth there are high levels of men and MSM whilst there are higher number of people born in Africa among Southwark residents.

LSL residents tend to attend GUM services outside of the boroughs. Less than half of Lambeth residents attended Lambeth or Southwark based GUM clinic (St Thomas, King's or Guy's hospital). In Lewisham the main reason has been the absence of GUM services in Lewisham, which in the future will not be factor as Lewisham now has a GUM service. (see Appendix 4 for detail on GUM service use)

Continuous modernisation of GUM services includes a focus on:

- Separating walk-in and complex appointment-based activity.
- Training staff to work in STI care and contraception.
- Shift non-complex cases into community and primary care settings, this includes medical gynaecology (PID and menorrhagia), as well as training primary care staff and providing a clinical governance role with supporting local guidelines and PGDs.
- Speeding up transit times.
- Modernisation and redesign of care pathways, e.g., for psychosexual services.

4.4.2 Modernising sexual health services and self-management

Modernising sexual health services includes introducing patient self-management, which can be cost-effective and popular with service-users. Self-management includes:

- Making services more accessible, for example shifting to community or schools settings (e.g. now that EHC is available in community pharmacy, very few women access it via specialist services).
- Self-booking appointments without the need to go through an additional healthcare provider (e.g. TOP self-referral and booking).
- 'Vending machines' in clinics for routine needs that do not require a consultation (e.g. pregnancy tests, condoms, Chlamydia screening
- Self-booking kiosks in services.
- Introducing user-friendly testing technology, which is administered by the service user, either urine based or involving self-taken swabs.

Online testing for STIs such as Chlamydia and Gonorrhoea testing via the "checkurself" website. Although self-management offers major advantages for both sexual health services and service users there are key challenges to overcome before implementation, including assessing the cost-effectiveness and whether service-users would prefer to see a health professional even when offered self-management.

Locally Lambeth and Southwark are developing SH24, a virtual, holistic, sexual health service that will use technology to empower users and improve efficiency and access.

SH24 will

- Expand access to clinical services: contraception and diagnosis and management of sexually transmitted infections via a web based service (24 hours a day) linked to telephone and specialist clinic support
- Provide better access to information, risk assessment, sexual health promotion and self management for all groups, including those who find it difficult to access mainstream services
- Provide a service which places the user at the heart of their care with user held records and tools for self management
- Deliver efficiencies by allowing less complex cases to use the on line service freeing up clinic time for people with more complex needs
- Deliver value for money through provision of a web based service at a lower cost per contact

SH24 will be delivered through a community interest company (SH24 CIC) representing a partnership between public health, specialist sexual health services, the Design Council and sexual health commissioners.

The service development will adopt a design led approach to ensure a focus on users needs throughout, with protocols developed to manage risks and ensure robust safeguarding.

What we will do
We will work towards a new service model whereby basic, uncomplicated needs are met in the community, with sexual health services focusing on complex cases, clinical governance for the whole system and training.
We will develop self-management options, which do not require attendance at a clinic, including making good use of new technologies.
We will assess the potential for improving efficiency in sexual health services by adjusting the mix of staff skills and roles.
We will develop new resources and information to promote access to services.

4.5 Psychosexual Services

4.5.1 King's College Hospital and GSTT provide psychosexual and sexual function services along with some provision in Lewisham and GSTT integrated sexual health services. South London & Maudsley Mental Health Foundation Trust (SLAM) also provides a comprehensive tertiary service. Commissioners and providers have reviewed these services via the South East London(SEL) Network and have developed clear pathways of matched care with clarity about what should be delivered in primary, secondary and tertiary care. These services are funded with a variety of block contract and a range of tariff arrangements and the current redesign project will ensure that patients are able to access the right service at the right cost. There remains work to be done to clarify funding sources for these services across the CCGs and Local Authorities. It is recommended that the review undertaken in SEL of psychosexual services is implemented, and mental health and sexual health commissioners align their plans and funding streams.

Key Messages
There is a need to further modernise psychosexual services to create seamless pathways that make best use of capacity and skills.
There is a need to move more of the non-complex caseload (including medical gynaecology) to primary

and community care settings nearer to home, which would require SRH providing an increased role in clinical governance, supporting local training guidelines and Patient Group Directions (PGDs).

What we will do
We will work with sexual health providers to ensure capacity is maintained and every contact counts.
We will explore optimal GUM and integrated sexual health contracting mechanisms with providers, including an analysis of adopting a variable tariff.
We will explore and pilot with GUM and integrated sexual health providers opportunities for outreach to vulnerable hard to reach groups.
We will work with GUM and integrated sexual health providers, CCG and service users to agree the optimum location of sites for community and integrated sexual health services and wrap-around primary care provision.
We will continue to work with local stakeholders towards a new service model whereby basic, uncomplicated needs are met in the community by self-management, primary care and pharmacy with sexual health services focusing on complex cases and out reach to vulnerable groups, clinical governance for the whole system and training. This will include supporting the development of the SH24 service.
We will collaboratively assess potential for improving efficiency through workforce review and adjusting the mix of staff skills and roles.

4.6 Primary care: general practice and community pharmacy services

4.6.1 There remains a national and local drive to increase access to sexual health and contraception in primary care, in order to make it easier for residents with non complex sexual health needs to access services closer home or work. Primary care is extremely accessible to the local community and is well accessed by many who may be at risk of HIV. Approximately 75-80 % of contraception is provided in primary care, and over a third of women found to be Chlamydia positive were identified from screening in primary care.

LSL have a long history of providing sexual health services in primary care. For example, LSL have adopted the Birmingham Sexual Health In Practice (SHIP) model for training in providing sexual health in primary care whereby GPs and practice nurses train others in a peer-led model that has been proved to be effective.

LSL have a range of Local Enhanced Service (LES) arrangements with general practices for activity that goes above and beyond the requirements of their national contractual arrangements (e.g. basic contraception). This has included the provision of LARC and complex STI care. The LES contracts do not apply to Local Authorities and new contractual arrangements are in development and aligned to the commissioning landscapes of the CCG. To prevent any fragmentation of provision, it will be vital to maintain dialogue with the CCGs and the primary care contracting function of NHS England. The range of LES commissioned in primary care in LSL are shown in Table8, along with the number of practices signed up LES by borough.

Table 12: General practice sexual Local Enhanced Services

General practice	Lambeth Practices	Southwark Practices	Lewisham Practices
Chlamydia screening	-	45	37
LARC	32	17	14
Sexual health	3	-	-

More information on local provision of LARC, Chlamydia screening and EHC can be found in Appendix 5.

Key Messages
Primary care remains a key setting for sexual health delivery.
More work needs to be done to match service delivery points with areas of high deprivation and need.
We will review our approach to developing and contracting local enhanced service delivery.

What we will do
We will continue to explore options for widening access to sexual health services through primary care, including reviewing options presented by the development of the SH24 service.
We will support the GP champion role, which has proved valuable in developments such as Chlamydia screening.
We will continue to improve access to LARC and EHC through primary care provision.
We will continue to contract with primary care for sexual health services, working with CCGs to develop and monitor sexual health LES.
We will agree priorities for primary care development and how training fits with incentives (e.g. condom schemes) and with any payment arrangements. Pathways may include aligning SHIP training to basic sexual health service provision with a progression to STIF and specific training to fit sub-dermal implants and IUD/S.
We will support the development of new information and resources, including SH24, that will improve access to services and signpost service users to the most appropriate and effective services.
We will review LES and assess feasibility and cost efficiency of integrated sexual health LES, bringing together LES for LARC, Chlamydia, HIV testing and sexual health.

4.6.2 Community Pharmacy

Community pharmacy has played an important role in the local sexual health economy in LSL, starting with the provision of EHC and continuing with successful Chlamydia and gonorrhoea screening programmes. A number of pharmacies are also commissioned to provide oral contraception for women with no medical complications and the evaluation of this service has shown it to be popular with women.

The current sexual health services provided in community pharmacies in LSL via LES contracts in LSL is illustrated in Table 11below

Table 13: Community pharmacy sexual health LES LSL

Community pharmacy	Lambeth	Southwark	Lewisham
Chlamydia treatment	4	26	0
Emergency Hormonal contraception	41	31	19
Oral contraception	3	3	4

There is scope to develop the role community pharmacies can play in sexual health and there is a willingness on the part of pharmacists to engage in this. Pharmacies can provide services closer to home, and many people chose to self-manage their sexual health with the help of local community pharmacies. They are seen as providing convenient and easy access, which is seen by many as more important than the anonymity of a specialist service.

Key message
Primary care is an under-used resource for localised sexual health. Providing sexual health services in community pharmacies and General Practice can increase access for priority groups and is popular with service users.

What we will do
We will continue to explore options for widening access to sexual health services through community pharmacy, including reviewing options presented by the development of the SH24 service.
We will assess which services are best provided in community pharmacy, how these will be funded and what development and training support will be made available in relation to their provision. The availability of HIV & other STI testing will be a priority.
We will support the skilling up of pharmacy staff in delivering sexual health services.
We will set up a sub-group of the LSL SH Commissioning Board to develop sexual health primary and pharmacy-based service provision and to examine public health needs data, service efficiency, cost benefits and user satisfaction to ensure a range of appropriate service provision can be commissioned and contracted from 2015.
We will strengthen clinical governance arrangements through the SEL Network and agree arrangements with CCG Medicines Management Committees.

4.7 HIV Care and Support

4.7.1 HIV treatment services are now commissioned by NHS England under the national specialised services portfolio. LSL have specialist HIV outpatient clinics at St Thomas' Hospital (Harrison Wing), King's College Hospital (Caldecott Centre) and Lewisham Hospital (Alexis Clinic). Following the disestablishment of South London Healthcare Trust and the formation of Lewisham and Greenwich NHS Trust, the Lewisham service has merged with the Trafalgar Clinic at Queen Elizabeth Hospital.

NHS England is carrying out a review of London HIV treatment services with a view to modernising services. Increasingly there will be a need to involve GPs in HIV care as patients get older and manage multiple long-term conditions. NHS England will set out what will be required of HIV services in supporting GPs.

In LSL, an HIV Care and Support review conducted in 2011/12 recommended a new service model for HIV support services, including a focus on self-management, and increasing the use of mainstream services in addition to maintaining specialist services for the relevant cohort. Recommendations from the review are currently being implemented. For more detail on the review see Appendix 6.

The Service User Reference Group (SURG) was developed to support the HIV Care & Support Review in 2010 and is facilitated by the South East London Sexual Health and HIV Network. It continues to work on issues of concern in HIV care and members have developed their role to get involved in other initiatives and in providing training. It has been highlighted as an example of good practice in user involvement in Lambeth and the model has been adopted for the London HIV Service Review.

What we will do
We will work towards a re-balance of specialist and mainstream care/support for people living with HIV in LSL to deliver improved services.
We will ensure the service user voice is central in the development of new care and support services, through on-going engagement and co-production. This will include continuing to support and develop the work of SURG.

We will ensure there is on-going evaluation & development of the evidence base for our care and support services.

4.8 Termination of Pregnancy (TOP) services

4.8.1 ' The purpose of a termination service is to provide terminations which are timely and safe depending on the personal health and circumstances of the individual service user, to reduce further unintended pregnancies and repeat termination and to promote better sexual health among service users'. (DH Service Specification, TOPs, Feb 2012)

LSL experiences a high volume of terminations of pregnancy, with Lewisham having the highest rates in England. Activity is high and volatile with approximately 6000 procedures performed annually. LSL currently has high levels of repeat terminations.

The LSL Sexual Health Commissioning Team commission TOPs on behalf of Lambeth, Southwark and Lewisham CCGs and reports into the LSL sexual health programme board. This successful collaborative commissioning arrangement has been in place for over 6 years.

In LSL, TOPs services are commissioned from four providers: Marie Stopes International (MSI); British Pregnancy Advisory Service (BPAS); Lewisham & Greenwich NHS Trust and King's College Hospital (KCH). MSI and BPAS provide the majority of terminations (90%). Access to Termination is managed through a commissioned Central Booking Service. Two specialist TOPs pathways are commissioned from KCH (10% of total activity): one pathway is for late gestations of >19 weeks and the other for terminations for women with complex medical needs.

Key messages
Reducing rates of repeat TOPS are a priority for LSL.

4.8.2 All commissioned TOPs providers are required to deliver to the Department of Health nationally mandated service specification for TOPs. This contains national and locally agreed Key Performance Indicators (KPIs), quality indicators, outcome targets and an annual service improvement plan. Care pathway for TOPs includes STI testing, including HIV testing as part of the implementation of national testing guidance (2008). As such it contributes to the reduction of HIV late diagnosis. It also includes access to all LARC methods, with a view to reducing repeat TOPs. Providers must deliver a quality service informed by the Royal College of Obstetricians and Gynaecologists Guideline for the Care of Women Requesting Induced Abortion.

For the past 5 years, all of these services have been meeting the national target of 70% of TOPs being performed at less than 10 weeks. This suggests that there is timely access for residents to TOP. More recently, MSI have opened a centre in Lewisham and are scoping out the potential for a site near Waterloo. All TOP providers have offered basic sexual health screening for Gonorrhoea, Chlamydia, Syphilis and HIV since the previous SH strategies have been implemented. The Waldron EMA service, however, are the only providers offering IBA Alcohol screening to all clients attending their service. The intervention screening approach follows NICE guidance and identifies higher risk drinkers and signposts appropriately. All three boroughs have high repeat TOP rates and to address this, contraceptive follow up post abortion is now commissioned from BPAS and MSI and will be reviewed. There are challenges in reducing levels of repeat terminations in LSL, given the relatively high levels of violence against women and girls in the borough. There is also an over-representation of BME groups among those accessing TOPs services and those accessing repeat terminations. More work needs to be to undertaken, in order to ascertain the

reason for this. There is, for example, some evidence that BME groups may be more likely to access local NHS TOPs services whilst other populations may access private clinics.

What we will do
We will conduct research into ward level analysis for repeat terminations and improve age-profiling to help identify trends and tackle trends for the most vulnerable girls and young people
We will work with providers and prioritise the prevention of repeat terminations.
We will increase access to LARC.
We will broadenthe prevention remit of TOP services to include the broader determinants of health, for example, where possible, introducing alcohol brief interventions.
We will work with TOP services to explore options for developing a pilot intervention focused on working with women and girls experiencing violence.

4.9 Young people's sexual health services and teenage pregnancy

Key messages
Safeguarding young people is central to our strategy and the services we commission.
Only by reaching out to the most vulnerable young people will we improve their sexual health in LSL.

4.9.1 WUSH (Wise Up to Sexual Health) is commissioned to provide targeted sexual health interventions to vulnerable young people in Lambeth and Southwark and to provide high quality sexual health services for all young people in Lambeth. The remit includes college and schools work. Brook is also commissioned to provide integrated sexual and reproductive health services and provides free and confidential sexual health advice, services and information for under 25s. This includes emergency contraception, condoms, pregnancy testing, referral for termination of pregnancy and STI screening. Brook also supports the pan London under 25s "Come Correct" 'C Card' condom distribution scheme in Lambeth. Lewisham is also a member of the Come Correct scheme, although has no specific local resource for this. All providers are Department of Health's "You're Welcome" accredited to ensure they are Young People friendly. Contraception is commissioned across a variety of settings across Lambeth, Southwark and Lewisham and this includes Long Acting Reversible Contraception, Oral Contraception and Emergency Hormonal Contraception. Teenage Pregnancy services are commissioned outside the LSL Sexual Health Commissioning Team. Individual borough Teenage Pregnancy strategies and interventions are aligned with LSL Sexual Health Commissioning Plans.

As part of the response to the sexual health needs of young people in Lambeth and Southwark a sexual health outreach service for young people was established; it was branded as WUSH – Wise Up to Sexual Health - following a consultation with young people. WUSH objectives are to promote good sexual and reproductive health and prevent sexual ill health for all Lambeth young people through providing accessible high quality sexual health services and to provide targeted sexual health interventions to vulnerable young people review of the service was undertaken in 2013 (see Appendix 6), and the results and recommendations can be found in section 10.3 of this document.

What we will do
We will review and refresh the WUSH service strategy and resourcing in the context of wider sexual health and young people's strategy.
We will support development of work with young people that focuses on sexual health within the context of the wider determinants of health.

Teenage pregnancy rates in LSL are to be found in Section 1.10 of this strategy

4.9.2 Lambeth Teenage Pregnancy Programmes

Lambeth has implemented an evidence-based teenage pregnancy programme to address prevention and provide support to teenage parents under the leadership of a strategic partnership across health and the local authority. The interventions are:

- A holistic Health and Wellbeing Programme.
- A targeted Boys and Young Men's Programme
- A Teens and Toddlers Programme.
- A Continuing Professional Development Programme for teachers, school nurses and other teaching staff
- The Schools Health Education Unit (SHEU) survey is completed in Lambeth schools every 2 years

Interventions to improve the health and wellbeing of young people in Lambeth continue to be effective; and it is important to ensure the work is sustainable in the tight financial climate. Under-18 conceptions ending in abortion continue to be high therefore there needs to be an emphasis on ensuring contraceptive services are meeting the needs of young people.

4.9.3 Southwark Teenage Pregnancy:

The range of interventions commissioned in Southwark in order to reduce under-18 conceptions, provide support to teenage parents and improve the general health and wellbeing of young people areas follows:

- Health Huts deliver a service in schools, youth service and other settings
- Straight Talking service for parents
- SRE lessons in schools.
- Young peer educators.
- Young Women's worker,
- Parenting programme for the most vulnerable parents
- Southwark condom campaign Training to Southwark staff and the voluntary sector

4.9.4 Lewisham Teenage Pregnancy:

Between 2010 and 2013 Lewisham implemented a teenage pregnancy strategy, which focused on four main areas:

- Sex and relationships education
- Access to prevention services
- Promotion, marketing and communication
- Support for young parents.

Since 2011, there have been significant changes within local government. Some of the services previously targeted at young people (such as Sure Start +) are now provided through targeted mainstream services such as children's centres. In addition to this over the same time period there has been an increase in the number of looked after children in the borough (who are at particularly high risk of teenage pregnancy) and a reorganisation of the youth support services which has meant that the level of input into the teenage pregnancy programme has reduced. In 2012, there has been a rise in teenage pregnancy rates in Lewisham compared to 2011. Since December 2013 the strategic responsibility for teenage pregnancy in Lewisham sits with public health and there is no longer a teenage pregnancy co-ordinator in the borough.

Sexual health services report anecdotally that there appears to be an increase in the number and complexity of vulnerable young people (particularly women) accessing their services. The experience of the Family Nurse Partnership, which has operated a caseload of 100 under 19s from early pregnancy since 2010, is similar.

Lewisham Council commissions the following interventions to support the teenage pregnancy agenda:

- School nurses run sessions in a youth centres to offer young people an opportunity to access support outside of school and mainstream service provision
- SRE delivered by sexual health and school nurses to secondary schools.
- Work with young fathers
- Drop in sessions run by the young persons midwife to support young parents.
- Pilot work with pharmacies around the provision of free condoms to young people through the CCard scheme.
- Sexual health training for foster carers and front line staff working with young people.

Following the reorganisation of the youth service, additional workforce development is planned including sexual health training and mental health training for youth service staff.

What we will do
We will explore work with local faith communities to deliver information about Teenage Pregnancy through existing provider networks.
We will sustain and develop community involvement.
We will continue to strengthen links and working partnerships with commissioners responsible for Teenage Pregnancy across Lambeth, Southwark and Lewisham.
We will strengthen and develop work in schools and in youth service settings to ensure high quality SRE is delivered to young people

4.9.5 Chlamydia screening

It is estimated that complications associated with Chlamydia costs the NHS at least £100 million annually (Chief Medical Officer's Experience Advisory Group). Much of this cost arises because early infection is largely asymptomatic and a large proportion of cases remain undiagnosed which leads to the later development of serious complications in untreated women

The National Chlamydia Screening Programme (NCSP) was established in 2003 to provide opportunistic screening and treatment for Chlamydia in young people under the age 25 years. Lambeth Southwark and Lewisham were amongst the boroughs in the first phase of the national roll out of this programme and are amongst the highest performing boroughs in terms of screening coverage and positivity. All three boroughs have mainstreamed Chlamydia screening into core services in line with national best practice and will continue to invest in measures to ensure screening coverage remains high and continues to improve.

Table 14: The number of tests, annual coverage and positivity for LSL

Borough	Number of Chlamydia test in GUM	Number of Chlamydia tests in other settings	Total number of tests	Number of positives all settings	Testing rate – test per 100 of target population
Lambeth	5806	14771	20577	1969	63
Southwark	6014	13938	19952	1868	51
Lewisham	1840	15010	16850	1539	52

Sources: HPA Lazer report 2011

What we will do
Although LSL are already achieving well above the national indicator for Chlamydia screening we will

contain to maintain or increase diagnosis and screening coverage.
We will prioritise interventions that prevent Chlamydia in recognition of the considerable downstream cost- savings this can offer.

4.9.6 Condom Distribution Schemes

The condom distribution schemes operating in LSL are as follows:

- LSL GP condom and pregnancy testing scheme
- LSL scheme providing condoms and lubricant to Voluntary and Community Sector organisations and local NHS organisations
- Pan London "Come Correct" C-Card Scheme for under 25's (Lambeth and Lewisham)
- Safer Partnership scheme for Black Africans
- Pan- London HIV Prevention Programme Scheme for MSM

A review of the free condom distribution schemes operational in Lambeth, Southwark and Lewisham was conducted in summer 2013. For further details of the schemes and findings from the review see Appendix6.

What we will do
We will adopt a phased approach to introducing an LSL-wide condom distribution scheme and LSL-wide GP scheme.

5. Cross- cutting issues

5.1 Workforce and Training

Given the sexual health needs of the population in LSL and the high STI and HIV rates and ever increasing numbers accessing sexual health services, there is a clear need to focus on service improvement. Services need to be more efficient and prevention-focused to meet the increasing need and to drive it down. Maintaining and developing the competencies of the workforce in both sexual health and mainstream services is key to modernising services, making them more efficient.

Key messages
Developing the skills of clinicians in non-sexual heath services to offer certain sexual health services will widen access and help ensure early intervention.
Changing the skills mix of clinicians in sexual health services will make these services more efficient, for example moving to nurse-led prescribing models, thereby reducing need for consultant time.
Promoting better sexual health can be achieved by training all those in contact with service users to raise the issue of prevention - 'making every contact count' - and to signpost or refer on as appropriate.

What we will do
We will improve efficiency and cost effectiveness of sexual health services by reviewing service users pathways with a view to improving the skills mix of staff.
We will review the need for training to better support the increasing use of Patient Group Directives (PGDs) so that staff from a broad range of disciplines can offer contraception and sexual health services.
We will review the need for training to better support the delivery of sexual health services in primary care and community pharmacy.
We will support the development of sexual health training for non-clinical staff and the workforce in mainstream services, with a particular focus on prevention.

5.2 Improving services for vulnerable people

Recent service reviews (See Appendix 6) and feedback from providers indicate that increasing numbers of highly vulnerable people are presenting routinely to sexual health services in LSL. These include young people, homeless people and women who are experiencing violence. Many present with sexual health needs and subsequently are found to have multiple and complex other needs. Frequently, serious safeguarding issues also emerge during the service user's contact with services.

Referrals to sexual health services from mainstream services working with vulnerable people are also increasing and frequently include safeguarding issues. For example, homeless hostels have been referring a disproportionately high number of women to sexual health services, most of whom are also victims of sexually exploitation. Vulnerable people also experience difficulties in accessing sexual health services, most usually accessing at the point of crisis, rather than earlier on when prevention would be most effective.

Key messages
We are currently missing opportunities to widen access to sexual health services, and particularly preventative services, for the most vulnerable populations in the boroughs. For example, extending sexual health services in pharmacies and primary care will increase access for those most in need.
We are missing opportunities to 'make every contact count', supporting the workforce in mainstream

services to raise sexual health and prevention at every opportunity and those in sexual health services to raise non-sexual health issues.

What we will do
We will work with providers to widen access to sexual health services and prevention for the most vulnerable populations in the boroughs.
We will work with TOP services to explore options for developing a pilot intervention focused on working with women and girls experiencing violence.
We will work with providers of homeless, mental health and disability services to determine effective prevention and support for vulnerable service users.
We will evaluate the Southwark CTAB pilot in substance misuse clinics, and consider rolling this out across the sector.
We will work towards an integrated approach to services, which encompasses “making every contact count”.

5.3 Reaching emerging populations

There is evidence that new immigrant populations have poorer sexual health. Indications are that recent migrants to LSL are at a greater risk of acquiring HIV and STIs than more established populations.

Further data gathering and analysis is required to determine which emerging populations are most in need (and to define that need) in order to inform appropriate service promotion and interventions. It is likely that interventions will need to be wide-ranging, encompassing more effective promotion of services and the development of new resources and targeted intensive interventions.

What we will do
We will work with our public health team to gather data and analyse the needs of emerging populations to inform our commissioning intentions.

6. Plan for consultation on this strategy and next steps

This strategy has been developed with wide stakeholder engagement. We are committed to ensuring that service user and other stakeholder views continue to shape its final version, implementation and review.

The draft strategy will be launched at a stakeholder event in April 2014. Focus groups will be held with key target groups that are a priority within this strategy i.e. young people; people from Black African communities; and MSM.

We will consult with the Health and Social Care Scrutiny panels in each borough.

We will consider and address all feedback and report the outcome of the consultation, plus the final strategy, to each borough's Health and Wellbeing Board by the end of June, subject to any restrictions on timescale imposed by local elections.

A action plan will be produced following approval of the final strategy.

We welcome and will consider any feedback on this strategy. Please email all feedback to: SHconsultation@lambeth.gov.uk

This strategy will be available on each borough and CCG website.

Glossary for LSL Sexual Health & HIV Strategy

1. Commissioning:

AQP — Any Qualified Provider – an arrangement whereby GPs particularly can chose from an approved list of providers. Has been applied to some London TOP services (not LSL).

CCG — Clinical Commissioning Group – the local GP-led NHS commissioning bodies.

CQUIN — Commissioning for Quality and Innovation - in NHS commissioning, an arrangement whereby a percentage of funding is withheld subject to quality criteria being met.

CSU — Commissioning Support Units – NHS bodies (3 in London) set up to support CCGs with practical aspects of contract management, finance, data management, etc.

LES — Local Enhanced Service – NHS arrangement whereby GPs and Community pharmacies are paid for activity above and beyond their main contracts, egg for GPs to provide costlier long acting methods of contraception rather than the contraceptive pill.

LETB — Local Education & Training Board – responsible for commissioning all pre and postgraduate education and training for NHS providers. There are 3 in London; south London has Health Education South London.

NHS England — Responsible for the general primary care contract and for commissioning specialised services including HIV treatment.

QIPP — Quality, Innovation, Productivity, Prevention – headlines aims for all providers but often attached to financial savings.

QOF — The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management, but resourcing and then rewarding good practice.

2. Services / provider issues:

BBV — Blood-borne viruses – it is often helpful to deal with HIV issues alongside other blood-borne viruses such as hepatitis B and C

BPAS — British Pregnancy Advisory Service – TOP provider

Cascaid — LSL HIV mental health team based at South London & Maudsley NHS FT.

Clinical Governance — – is a range of activities whereby the NHS addresses issues of quality and risk in clinical services. It can include training, audit and the development of guidelines and policies. In the sexual health context, specialist services have a clinical governance role in relation to primary care and therefore develop guidelines and teaching programmes. Clinicians are available to give advice to generalist clinicians on sexual health clinical issues.

EHC — Emergency Hormonal Contraception. Often referred to as the ‘morning after pill’. Widely available from community pharmacies.

GUM	Genito-Urinary Medicine – usually in acute (hospital) settings and funded via the GUM PbR tariff. Increasingly, services are working in an 'integrated' way, i.e. providing STI and contraception services together.
GSTT	Guy's & St Thomas' NHS Foundation Trust
HPE	HIV Prevention England – nationally commissioned HIV prevention activity mainly for MSM
KHP	King's Health Partners – the local Academic Health Science Centre; a partnership of GSTT, King's, SLAM & King's College London. It is primarily concerned with ensuring the results of research find their way into service delivery and training & education. Also encourages collaboration where this makes sense.
LARC	Long Acting Reversible Contraception – includes implants and IUD/S (intra-uterine devices/systems also known as coils). More effective than other methods and cheaper long term.
MSI	Marie Stopes International –TOP provider.
MSM	Men who have Sex with Men – a term used to describe men who identify as gay or bisexual and also those who do not (including those who identify as heterosexual) but have sex with other men. The term defines the sexual route through which men may be exposed to the risk of HIV, rather than the sexual orientation by which the individual may self-define.
PEP	Post Exposure Prophylaxis – a dose of HIV antiretroviral medication administered after someone is known to have been at direct risk either sexually, or occupationally (egg a healthcare worker)
PbR	Payment by Results i.e. the pricing mechanism for all hospital-based activity. The name is misleading, as it is really payment by activity. There is a GUM PbR tariff – currently recommended to be £ xxx for a first attendance and 3xx for follow up. These are NHS arrangements and the tariff for GUM is no longer mandatory.
PGD	Patient Group Direction – an arrangement whereby a healthcare worker can administer a treatment under very specific circumstances only, egg, a non-prescribing nurse providing antibiotics in cases of uncomplicated Chlamydia. Also used in community pharmacy, egg for Chlamydia treatment.
PLHPP	Pan London HIV Prevention Programme
PrEP	Pre Exposure Prophylaxis – still undergoing clinical trials, this is an approach to HIV prevention whereby a dose of HIV antiretroviral medication is administered before any potentially risky activity, e.g. unprotected sex
PSHE	Personal Social Health and Education
Psychosexual	A range of services designed to improve sexual function by way of medical and/or psychological interventions. There are delivered by both sexual health and mental health services, as well as in the private sector.
RSH / SRH	Reproductive and Sexual Health / Sexual & Reproductive Health services – community based sexual health services formally known as 'family planning'. Their focus was primarily on contraception and their staff were from an Obstetrics and Gynaecology background but this has changed as they now do a lot of STI screening and work with men also. In some areas they are known as CASH (Contraception & Sexual Health) services.

SH24	An initiative funded by the Guy's & St Thomas' Charity to provide online sexual health services in Lambeth & Southwark.
SRE	Sex & Relationships Education.
TOP	Termination of Pregnancy (abortion) services.

3. Professional bodies:

BASHH	British Association of Sexual Health & HIV
BHIVA	British HIV Association

Faculty of Sexual & Reproductive Healthcare (of the Royal College of Obstetricians & Gynaecologists)

4. Teaching:

DFSRH	Diploma of the Faculty of SRH – involves e-learning, 5 taught sessions and a clinical placement.
HEI	Higher Education Institution. In LSL, this usually means King's College London though the University of Greenwich and South Bank University are also used.
SHIP	Sexual Health In Practice – a peer led training programme for GPs and practice nurses developed in Birmingham & now provided by the Network in LSL and Bromley.
STIF	Sexually Transmitted Infection Foundation course.

5. National bodies

NICE	National Institute for Health & Care Excellence
PHE	Public Health England – now includes the surveillance and data functions of the former Health Protection Agency (HPA)

6. Data:

CTAD	Chlamydia Testing Activity Dataset
GUMCAD	GUM Clinic Activity Dataset. This is being developed further in recognition of the fact that a lot of STI diagnoses are made outside GUM settings.
PACT	Prescribing Analysis and Cost Tabulation data from general practice is a national data set, which analyses prescribing data in terms of cost and number of items (volume). At an organisational level, PACT is used to monitor and control prescribing cost and to set prescribing budgets.
SOPHID	Survey of Prevalent HIV Infections Diagnosed.

Appendix 1: National Recommendations

Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

Local authorities are responsible for providing comprehensive, open access sexual health services. The prioritisation and provision of appropriate services can be shaped locally via Joint Strategic Needs Assessments, and guided by the Public Health Outcome Framework and Framework for Sexual Health Improvement.
Local epidemiological STI and HIV data can be employed to inform service commissioning and provision, and to make the case for prioritisation of sustained investment in prevention and control interventions, targeting populations most at risk.

Every effort should be made to eliminate local barriers to testing, made available free and confidentially at easily accessible services. Alongside the effective clinical response, promoting safer sexual behaviour among individuals – including condom use and regular testing – remains crucial.

HIV
The Public Health Outcomes Framework includes an indicator to assess progress in achieving earlier HIV diagnoses. Locally, Joint Strategic Needs Assessments can be used to prioritise and inform the provision of appropriate HIV testing services, to deliver against this indicator.

In local authorities with a diagnosed HIV prevalence greater than 2 per 1,000, implementation of routine HIV testing for all general medical admissions and for all new registrants in primary care is recommended.

Chlamydia
The Public Health Outcomes Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults. This recommends local areas achieve an annual chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population.

The chlamydia diagnosis rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and genitourinary medicine services. Areas achieving or above the 2,300 diagnosis rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate.

Gonorrhoea
Reducing gonorrhoea transmission, and ensuring treatment resistant strains of gonorrhoea do not persist and spread remains a public health priority. The Gonorrhoea Resistance Action Plan for England and Wales (April 2013) makes recommendations on ensuring prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission.

Sexual health messages for the general public
Prevention messages should be promoted to all sexually active men and women, highlighting that individuals can significantly reduce their risk of catching or passing on HIV or an STI by:

- Always using a condom correctly and consistently when having sex with casual or new partners, until all partners have had a sexual health screen.
- Reducing their number of sexual partners and avoiding overlapping sexual relationships.

Engaging high-risk groups

Prevention programmes engaging specific groups at highest risk of HIV and STI infection should continue, including clinicians taking every opportunity to recommend:

- Sexually active under 25 year olds should be screened for chlamydia every year, and on change of sexual partner.
- Men who have sex with men having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly.
- People from black African and black Caribbean communities should have a HIV test, and a regular HIV and STI screen if having unprotected sex with new or casual partners.

Appendix 2: LSL Sexual health budgets 2013/14

Budgets for sexual health services commissioned by Local Authorities				
Sexual health service areas	**Lambeth**	**Southwark**	**Lewisham**	**Total**
Clinical services				
GUM	£7,496,643.00	£6,169,527.00	£2,228,594.00	
RSH/Integrated SHS	£3,951,303.00	£ 4,331,554.00	£4,000,000.00	
Brook	£ 264,921.00	£ 276,419.00	-	
WUSH	£ 261,635.00	£ 78,000.00	-	
SE London Sexual Health Network	£ 15,000.00	£ 12,328.00	£ 10,700.00	
TDL Chlamydia screening management and online testing	£ 15,284.51	£ 13,249.00	£ 13,380.00	
Guy's & St Thomas's; King's College Chlamydia Lab costs	£ 25,471.00	-	£ 4000,00	
Total	**£12,030,257**	**£10,881,077**	**£6,256,672**	**£29,168,006**
Prevention Services				
HIV Pan London prevention services	£ 75,249.00	£72,571.00	£59,451.00	
SAFER Partnership WS1 (AAF, NAZ Project, Ethnic Health Foundation)	£ 67,347.00	£56,336.00	£ 54,766.00	
SAFER Partnership WS2 (African Culture Promotions)	£ 17,118.00	£14,320.00	£ 13,920.00	
SAFER Partnership WS3 (SHAKA Services)	£ 43,485.00	£36,376.00	£ 35,362.00	
African Health Forum	£ 11 322.00	£ 9,471.00	£ 9,207.00	
Health promotion team	£ 66,858.00	£ 52,809	-	
Freedoms condom scheme (C-Card and community				Capped at £95,000.00 (not included in total)
GP pregnancy test and Condom scheme				Capped at £65,000 across LSL (not included in total)
Brook C card scheme (Lambeth)	£ 56,304.00			
Pharmacy condom scheme	£ 2000.00	-	-	
Total	**£ 339,683**	**£241,883**	**£172,706**	**£754,272**
Primary care services				
GP Sexual health LES	£ 143,200.00	-	-	
GP LARC LES	£ 138,765.00	£112,524.00	£29,000.00	
GP Chlamydia screening	-	£ 54,575.00	-	
Community Pharmacy sexual health LES (EHC, Oral contraception Chlamydia treatment	£ 82,300.00	£ 119,956.00	£170,157	
HIV testing in primary care	£ 45,000.00	-	£ 45,000.00	
GP champion	£ 13,000.00	-	£ 15,000.00	

Total	**£ 422,265.00**	**£287,055.00**	**£259,157**	**£968,477.00**
Overall budget	**£12,792,205**	**£11,410,015**	**£ 6,688,535**	**£30,890,755**

Budgets for sexual health services commissioned on behalf of LSL CCGs,				
	Lambeth	**Southwark**	**Lewisham**	
TOP services				
BPAS	£428,848.00	£ 354,622.00	£312,115.00	
MSI	£ 451,170.00	£ 405,032.00	£ 418,764.00	
LHNT	-	£ 10,199.00	-	
KCH	£229,000.00	£126,000.00	£296,000.00	
Vasectomy (BPAS)	£ 3906.00	£ 5208.00	£ 11,718.00	
Central booking service	-	£ 15,000.00	-	
Total	**£1,112,924.00**	**£916,061.00**	**£1,038,597.00**	**£3,052,582.00**
HIV Care and support				
Mildmay	£ 313,075.00	£ 114,073.00	£102,644.00	
SLHIVP	£ 302,256.00	£ 243,602.00	£144,232.00	
AAF Peer support	£ 3,019.00	£ 2,525.00	£ 2525.00	
CASCAID	£ 455,510.00	£ 387,738.00	£376,931.00	
Positively Parenting and Children	£ 84,453.00	£ 70,645.00	£ 68,676.00	
GSTT CNS	£ 180,583.00	£ 151,285.00	£ 147,069.00	
Total	**£ 1,954,227.00**	£ **969,868.00**	**£ 842,077.00**	**£3,766,172.00**
Overall budget	**£3,067,151.00**	**£1,885,929.00**	**£1,880,674.00**	**£6,818,754.00**

Appendix 3: Sexual health services in Lambeth, Southwark and Lewisham

Table 1 – Overview of Provision of Sexual Health Services

Provider->	Self-mgt	VCSO	School	GP	Pharmacies	RSH	Acute Trust/GUM
Reproductive health							
Condom distribution	X	Come Correct C-Card Scheme	WUSH	X	X	X	X
Pregnancy testing	X	Brook		X	X	X	X
Termination of pregnancy referral	X	Brook		X		X	X
Termination of pregnancy							X
Emergency contraception		Brook (check provision)		X	X	X	X
Contraception - hormonal		Brook/ Marie Stopes, BPAS		X	X (3 OC pilots -PGD)	X	X
Contraception- IUD & implant		Brook/ Marie Stopes, BPAS		X		X	X
Gynecological treatment				X		X	
cervical cytology				X		X	
STI acute							
Health promotion/ prevention of infection	X	X		X	X	X	X
Testing STI (CT & GC) - asymptomatic	X	Brook		X	X (attached to EHC LES)	X	X
Testing STI symptomatic		Brook		X		X	X
Partner notification	X	X		X	X	X	X
Warts Treatment				X		X	X
HIV							
HIV testing	THT pilot	Brook/ TOP services		X		X	X
HIV treatment							X
HIV PEPSE							X
HIV information/		SEL					
Information/ health promotion / behavioural interventions							
	X	Michael Fellowship		X	X	X	X
STI Prevention							
HPV vaccination			School nurses	X			

Targeted & specialist services							
Young people	X	Brook / Well Centre		X		X (STIs)	
MSM		Pan London		X		X	
Prison							
IVD users				X		pilot	
Violence		Haven / Brook/ GAIA		X			X
Sex workers		Streatham agencies		X			
Asylum seekers/refugees				X		X (3 borough)	
Homeless				X		X (3 borough)	

Sexual health services in LSL are provided by: general practices; pharmacies; community reproductive and sexual health services (RSH): Genito Urinary Medicine(GUM) services or equivalent provided by Acute Trusts; and community and voluntary sector organisations (CVSO). Some services are also provided within school. All services are open access for health protection reasons.

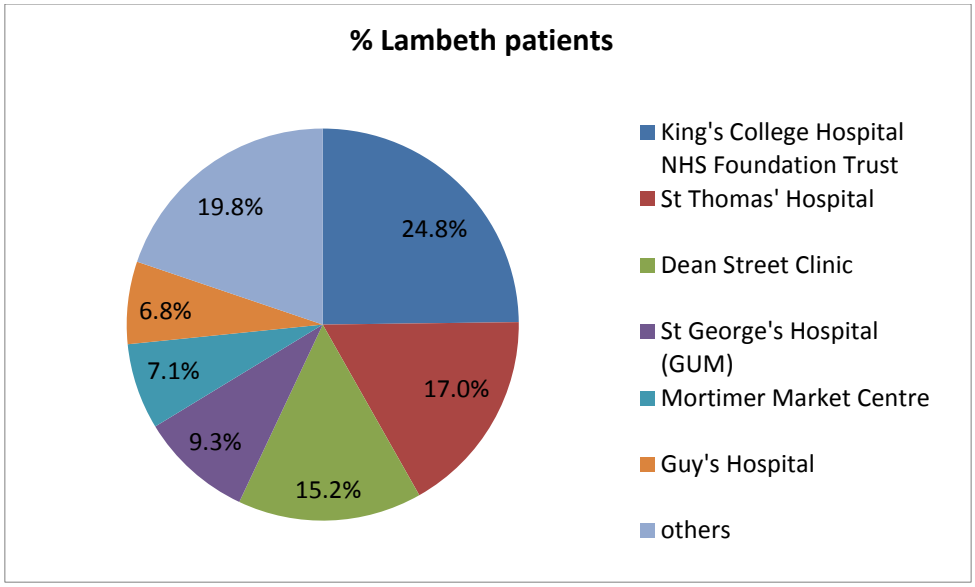
Appendix 4: GUM Service use in LSL 2008 and 20012

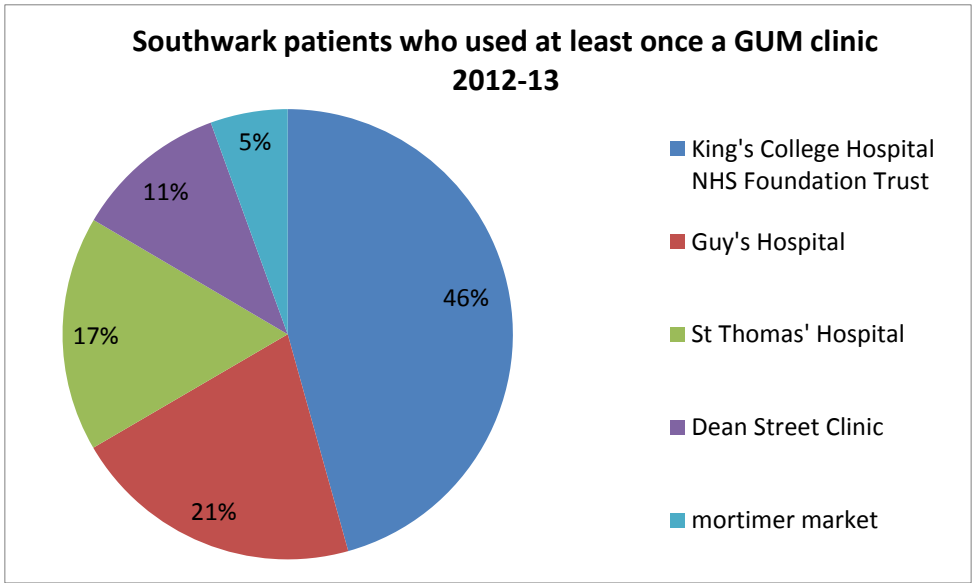
The information below is based on data contained in GUMCAD2 , the Genitourinary Medicine Clinic Activity Dataset version 2 . It is an anonymised patient-level electronic dataset collecting information on diagnoses made and services provided by GUM clinics and other non-GUM commissioned sexual health services.
Activity is attributed to "PCT" based on postcode of patient's GP. If not available, it is based on patient's postcode, and if not available it is attributed based on the hospital location
The overall coverage of GUM services for 2012-13 was 6.3 % of all age population resident in LSL. GUM service coverage was higher in Southwark (8.1%) compared to Lambeth (7.8%) and lowest in Lewisham (2.9%). The variability of GUM coverage between the boroughs is the result of various factors: there is no GUM clinic in Lewisham; there are differences in the size of the population at risk; and different patterns of use of existing sexual health services.

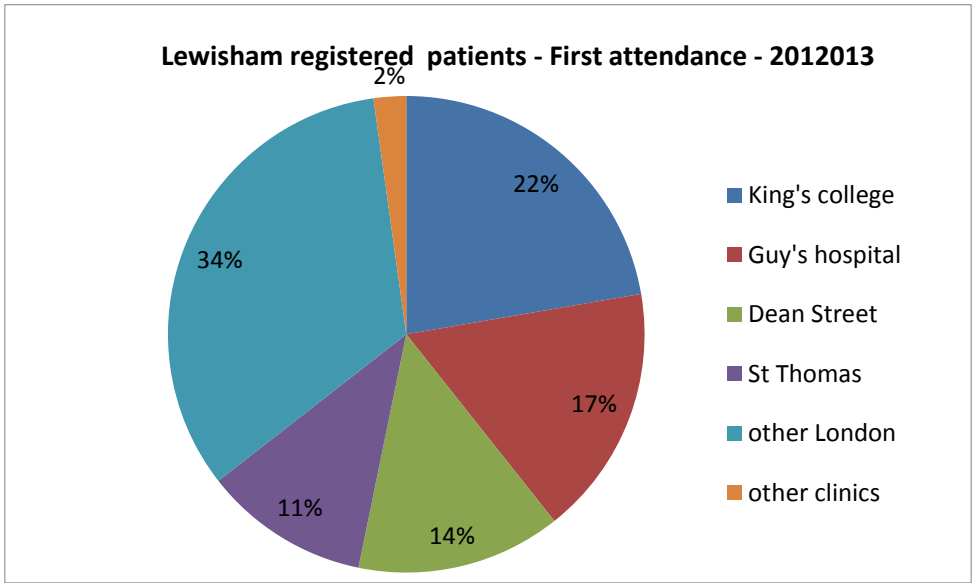
Volume of service 2012-13

2012	**Lambeth**	**Southwark**	**Lewisham**
Patients with at least one contact	23,749	23,270	8,105
First attendances (new episodes)	33,362	27,160	10,934
All attendances	46,981	43,117	15,934
2008	**Lambeth**	**Southwark**	**Lewisham**
Patients with at least one contact	12,007	7,558	4,179
New attendances	17,263	10,943	5,832
Total attendances	26,968	17,865	9,520
Change 2008 to 2012	**Lambeth**	**Southwark**	**Lewisham**
% increase patients	97.8%	207.9%	93.9%
% increase new attendances	59.7%	90.8%	53.6%
% increase all attendances	74.2%	141.3%	67.4%

The tables below illustrate GUM service use by LSL residents both in and out of borough.


% Lambeth patients
24.8%
17.0%
15.2%
9.3%
7.1%
6.8%
19.8%
King's College Hospital NHS Foundation Trust
St Thomas' Hospital
Dean Street Clinic
St George's Hospital (GUM)
Mortimer Market Centre
Guy's Hospital
others


Southwark patients who used at least once a GUM clinic 2012-13
46%
21%
17%
11%
5%
King's College Hospital NHS Foundation Trust
Guy's Hospital
St Thomas' Hospital
Dean Street Clinic
mortimer market


Lewisham registered patients - First attendance - 2012013
22%
17%
14%
11%
34%
2%
King's college
Guy's hospital
Dean Street
St Thomas
other London
other clinics

Appendix 5: Local Provision of Long Acting Reversible Contraception (LARC), Chlamydia Screening and Emergency Hormonal Contraception (EHC)

LARC

National estimates suggest that around a third of all pregnancies are unplanned. The effectiveness of contraceptive methods such as the oral contraceptive pill are dependent on correct and consistent usage. In 2005 NICE advocated the effectiveness of long-acting reversible contraceptive (LARC) in reducing unplanned pregnancy and teenage conception. LARC methods, once fitted, do not require daily compliance. A vital part of the availability and access to LARC is patient awareness and the availability of trained competent staff. There is currently a gap in knowledge regarding the number of staff trainers and trained staff in LARC methods.

Chlamydia Screening

In 2010-11 the local enhanced service contracts were revised to reflect the increased national chlamydia screening programme target of 35%. GP's in Lambeth were unable to achieve 35% coverage, with the maximum average level being 14% screening coverage of registered 15-24 year olds. Following a Lambeth evaluation in April 2011 of the portfolio of sexual health LES the GP Chlamydia LES contracting ended and the hours reduced within the sexual health LES. The money saved from this was re invested in Long Acting Reversible Contraception (LARC) LES, an area where demand had increased.

EHC

Lambeth, Southwark and Lewisham like several other inner London Boroughs have much higher rates of unplanned pregnancy, and repeat abortions than the national average.[1, 3] These boroughs have high levels of social deprivation which can negatively impact on contraceptive knowledge and access to community sexual health services and emergency hormonal contraception (EHC). Emergency Hormonal Contraception is cost-effective method in reducing unintended pregnancies (Trussell et al,1997, Glasier et al 1998). Early access to EHC provides a safe method for women in preventing pregnancy following unprotected sexual intercourse. In an attempt to tackle high conception and TOP rates in LSL much has been done to improve and increase access to EHC. However these services still require review and evaluation to ensure that they are best meeting the changing needs of the resident populations. Free EHC is available to LSL residence via Community pharmacies', General practice, A/E, TOP service and integrated sexual health services. Lambeth also leads the way in terms of HIV care in general practice with two pilots currently being delivered.

Appendix 6: Recent reviews

1 Summary of HIV Care and Support Review, 2012

A review of all LSL HIV Care and Support provision (specialist support services for people living with HIV which are separate to HIV drug treatment services) was undertaken in 2011/12 to ensure that services are modernised to reflect the changing needs of HIV Positive patients in light of treatment advances & disease pattern changes. The organisation is currently in the Implementation phase of the programme.

The review process included a Project Steering Group & Service User Reference Group, a refresh of the local epidemiology, a review of Needs and an Evidence Review, Service Review, development of Service model & Commissioning Intentions, 3 month full Public Consultation including Focus Groups, Consultation Events and Surveys and final recommendations and transition plan.

Transition Planning Principles include working towards a re-balance of specialist & mainstream service provision for PLHIV, transition leading to improvements for users, ensuring service user voice is central through on-going engagement and co-production, adopting a collaborative commissioning approach, planning for the future as HIV is increasingly a mainstream general public health issue in LSL and therefore needs careful attention to planning services and funding streams and a commitment to providing seamless pathways. Transition will rely on re-investment of existing resources into HIV Pathway development, ensure there is a fair price for services, mitigate against loss of specialist skills and destabilisation of the health system and there will be on going evaluation & development of the evidence base.

The current portfolio consists of: Specialist Mental Health Services for People Living with HIV: CASCAID services within SLAM, HIV Community Specialist Nurses, Specialist inpatient / day patient Service for People Living with HIV with neurocognitive impairment: Mildmay, Peer Support Services, South London HIV Partnership services and HIV Care and Support for Families and Children infected/affected by HIV. The total cost = £3 million.

2 Summary of Review of Condom Distribution Schemes, 2013

A review of condom distribution schemes operational in Lambeth, Southwark and Lewisham was conducted in summer 2013. The schemes operating in LSL are as follows:

- GP condom and pregnancy testing scheme operational in Lambeth, Southwark and Lewisham. In Lambeth and Southwark the scheme targets anyone attending GP practices (depending on method of distribution this may include non-registered patients). In Lewisham the scheme targets young people under 25 and those most at risk of HIV and STIs.
- Lambeth, Southwark and Lewisham Community scheme provides condoms and lubricant to Voluntary and Community Sector organisations and local NHS organisations for distribution to service users.
- Lambeth C-Card Scheme distributes condoms and lubricant to young people under 25. Brook Lambeth administer the scheme, identify Easy Access Points (EAPs) from where condoms are distributed and train staff at EAPs to distribute condoms. Young people visit EAPs, register, receive an SRE intervention and are given condoms and condom card. At repeat visits activity and demographic details are collected against the card. The Lambeth C-card scheme was positively evaluated in 2012 (Evaluation of Lambeth Come Correct Condom Distribution Scheme, 2010-212. Lambeth PCT, Rosa Weisskopt, 2012)

- Lewisham C-a card scheme is managed by managed by Health Improvement Programme Manager (Sexual Health). Young people register for scheme online or at distribution points. The Health Improvement Programme Manager trains staff at distribution points, administers scheme and manages logistics
- Safer Partnership scheme distributes condoms to BME community via businesses (barbers, hairdressers, nail bars, clubs, cab offices) and community venues
- Pan- London HIV Prevention Programme Scheme distributes condoms MSM via clubs, bars, SOPs and community venues

Both Lambeth and Lewisham C-Card scheme are part of the Pan-London Come Correct scheme. This allows young people to access condoms in all boroughs within Come Correct scheme
Southwark Teenage Pregnancy team also distribute condoms at Health Huts or at events primarily.

Although not included in the Review condoms are also distributed by: GUM and RSH services; pharmacies providing emergency hormonal contraception; and South London and Maudsley Trust community drug services.

Findings from the Review
The review found that there were potential savings offered by merging schemes, progressing towards one LSL-wide C-Card scheme targeting young people and adults at risk of HIV and STIs. Centralising into one LSL-wide scheme offers better value for money, especially given opportunity for economies of scale, as well as improved monitoring and reporting. It also allows for the introduction of robust quality assurance systems across all three boroughs to ensure condoms are distributed equitably and reach those most in need. The Review also recognised that, to avoid duplicating data collection systems GPs would be not join C-card scheme, instead GP schemes could be incorporated into LES contracts to ensure robust quality assurance.

Recommendations:
It is recommended that between 2014-16 a phased approach is adopted to introducing an LSL-wide C-card and LSL-wide GP scheme. This will comprise of

- Reviewing LSL Community schemes and drawing up simple criteria for membership of the scheme as an interim measure until new adult C-card in place
- Adopting an LSL-wide young people's C-card scheme and reviewing fit with adult C-card scheme.
- Reviewing best models for a joint adult and young people's C-card scheme and adopting an adult and young-people's scheme
- Adopting an LSL-wide GP scheme

This process will have the added benefit of synergy with the approach of developing a Pan-London condom distribution programme recommended by the London London-wide HIV Needs Assessment (2013), should the latter be adopted

In addition this work will be strengthened by

- Continuing to review SLAM scheme
- Reviewing GUM/RSH Condom Provision

3 A Review of Wise Up to Sexual Health (WUSH), 2013

As part of the response to the sexual health need of young people in Lambeth and Southwark a sexual health outreach service for young people was established; it was branded as WUSH – Wise Up to Sexual

Health - following a consultation with young people. WUSH objectives are to promote good sexual and reproductive health and prevent sexual ill health for all Lambeth young people through providing accessible high quality sexual health services. As part of the Reproductive and Sexual Health Service (RSH), within the community services directorate at Guy's and St Thomas's Foundation Trust, the WUSH team is to provide good quality clinical services to young people in Lambeth and Southwark in a variety of settings in order to improve the sexual health and wellbeing of vulnerable and 'at risk' young people. The service provides clinical outreach sessions in schools and out of school settings and further education (FE) colleges. It offers intensive one to one work with children in care and other vulnerable young people, referrals are made directly into the service from RSH, social care and from schools and out of school settings. The service also offers training to professionals (e.g. midwives, FE tutors etc.) and provides sexual health education to young people in FE and alternative education settings. WUSH Service Costs are £274K (Lambeth - £196K; Southwark - £78K.

The WUSH service model has been operational in Lambeth since 2007. The move of sexual health commissioning responsibility from the NHS to the local authority provided an ideal opportunity to evaluate the impact and effectiveness of the sexual health outreach service for young people in Lambeth and determine whether the current model is the most effective for achieving maximum impact (reducing unplanned teenage pregnancy and sexual ill health) and on-going sustainability.

An evaluation by an independent consultant team was undertaken in 2013 and the major focus of the findings was around the need to re-focus the priorities of the service and to target more effectively.

Key findings from the evaluation of the WUSH service were:

- WUSH's specialist expertise, clinical services and flexibility is rated highly by professionals who work with the service. However, given the need, the service is spread too thinly and, inevitably, can only reach a minority of young people in Lambeth and Southwark
- The expectations placed on WUSH are ambitious given the resources GSTT are devoting to it and given the current staff complement.
- In some WUSH service areas there is a mismatch between the levels of competency and the services provided e.g. some of the roles do not require highly qualified clinical staff (e.g. teaching, condom distribution).
- There is a need for sexual health services in schools, however, WUSH, in its current form, is not best suited to provide this.
- WUSH's 1 to 1 service is very highly rated by other professionals working with the service; however, it is labour intensive and may dominate the future service offer.
- WUSH aim to take in account broader health and social care outcomes for young people. Sexual health targets alone do not reflect the current service offer.
- WUSH needs to be better promoted, the move into GSTT may have made the service less visible.
- It is unclear who the key target groups for WUSH are – currently the focus is moving towards the most vulnerable young people.
- The size of service puts it at risk when there is staff sickness/ absence.

Key recommendations from the evaluation of the WUSH service were:

- WUSH service strategy and resourcing should be reviewed and refreshed in the context of wider sexual health and young people's strategy

- A new model for school drops-ins should be developed. This could include training up appropriate staff or young people to distribute condoms and could take the form of general health advice drop-ins and be promoted as such. The role that schools nurses could play in providing access to sexual health in schools should be agreed
- Explore the feasibility for commissioning sexual health clinical services for young people that sit within a holistic model of service provision, bringing together commissioners in children's services and sexual health services (as a minimum – there is also scope for including other commissioners e.g. mental health and substance misuse).
- If a holistic model is not feasible then schools nursing, health visiting services and other sexual health services contracts should be reviewed to ensure that these services are actively engaged in delivering an integrated offer for young people that includes sexual health.
- WUSH intensive support / 1 to 1 service should be reviewed in the context of a developing a wider service strategic plan. Service specifications for the service should be fully detailed in the SLA.
- Although there is a need for SRE sessions in colleges this should not be a priority for the current WUSH team. If it is to be delivered as part of the service then workers should be recruited with competencies in delivering SRE and there is no necessity for these to be clinical staff.
- WUSH's development would be helped by a review of SRE provision; including a focus on what Brook are delivering, and where the gaps may exist.
- WUSH should continue to deliver sexual health training with professionals
- The development of a service strategy for WUSH should include a promotional strategy.

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