Open Agenda

Healthy Communities Scrutiny Sub-Committee

Tuesday 8 July 2014
7.00 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Membership

Councillor Rebecca Lury (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Jasmine Ali
Councillor Paul Fleming
Councillor Maria Linforth-Hall
Councillor Kath Whittam
Councillor Bill Williams

Reserves

Councillor Maisie Anderson
Councillor Neil Coyle
Councillor Eliza Mann
Councillor Claire Maugham
Councillor Johnson Situ

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

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Contact
Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 30 June 2014

PRINTED ON RECYCLED PAPER

Healthy Communities Scrutiny Sub-Committee

Tuesday 8 July 2014
7.00 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**MINUTES** The minutes of the previous health scrutiny committee's last meeting, held on 5 March 2014, are attached, for reference.	1 - 7
5.	**SOUTHWARK CLINICAL COMMISSIONING GROUP (CCG) AND SEL COMMISSIONING STRATEGY** Andrew Bland, CCG Chief Operating Officer and Dr Jonty Heaversedge CCG chair, will present an introduction to the Clinical Commissioning Group. A paper is attached. Andrew Bland, CCG Chief Operating Officer, will present the South East London (SEL) five year commissioning strategy. A presentation is attached.	8 - 41

Item No.	Title	Page No.

6. KING'S COLLEGE HOSPITAL NHS TRUST ELECTIVE SERVICES PROPOSALS 42 - 51

King's College Hospital NHS Trust (KCH) will present the following proposals:

a)Transfer of elective adult inpatient orthopaedics from Denmark Hill & Princess Royal University Hospital (PRUH) to Orpington Hospital

b)Transfer of elective inpatient gynaecology from Denmark Hill to PRUH

c) Transfer of non-complex cataract surgery from Denmark Hill and PRUH
to Queen Mary's Hospital (QMH)

Detailed proposals are attached.

KCH representatives Sue Field, Head of Capacity Planning & Service Development and consultant, Dr Polly Edmonds will present. Andrew Bland, CCG, will be in attendance.

7. SEXUAL HEALTH STRATEGY 52 - 111

The Lambeth, Southwark & Lewisham Sexual Health Strategy and Consultation will be presented by Rebecca Adeojo, lead senior sexual health commissioner (Lambeth Council) and Kerry Crichlow, Director Strategy & Commissioning (Southwark Council). Papers are attached.

8. SCRUTINY REVIEW 112 - 115

A draft of the proposed reviews and their Terms of Reference is attached.

9. WORK-PLAN 116

The committee's work-plan for the year.

A paper attached sets out the committee's power.

10. TRAINING

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

Item No.	Title	Page No.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 30 June 2014

Open Agenda

Agenda Item 4

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Wednesday 5 March 2014 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Rowenna Davis
Councillor Dan Garfield
Councillor Jonathan Mitchell
Councillor Michael Situ

OTHER MEMBERS PRESENT:

OFFICER & PARTNER SUPPORT: Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group
Gwen Kennedy, Director of Client Group Commissioning (SCCG)
Tamsin Hooton, Director of Service Redesign, (SCCG)
Deborah Klee, Independent Chair of Southwark Safeguarding Adults Partnership Board
Jon Newton, Service Manager , Children's and Adult Social Services , Southwark Council
Julie Timbrell, Scrutiny Project Manager, Southwark Council

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Capstick. Councillors Situ and Mitchell gave apologies for lateness.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the previous meeting will be available at the next meeting. A draft summary of decisions has been published online.

5. VULNERABLE ADULTS ANNUAL SAFEGUARDING REPORT & PRESENTATION.

5.1 The chair invited the Independent Chair of Southwark Safeguarding Adults Partnership Board, Deborah Klee, Jon Newton, Service Manager and Gwen Kennedy, the CCG director responsible for safeguarding to present the Southwark Safeguarding Adults Partnership Board Annual Report 2012-13.

5.2 The Service Manager began by explaining that the report was led by the previous Independent Chair, Terry Hut. The report contains a response to the Care Bill, although things have now moved on. The report gives a statistical analysis of referrals; there has been a 6.6% rise, but 20 % requiring further investigation. This is comparable to national rise of 4%. There is work being done to determine thresholds, so we are comparable to partners.

5.3 The Independent Chair explained that she will be picking up on priorities for the coming year. She said that the first priority is to ensure the board is fit for purpose, this means the partners are really committed and that there is a strategy. One of the strategic priorities is getting the message out to the public. She reported that she is looking to have all the partners chairing each sub group, one is on quality and performance that the CCG director chairs. The board will also being looking at governance relationships with other boards, for example the Health and Wellbeing Board.

5.4 A member commented on the statistic noting that 8.1% of times the perpetrator is listed as ‘not known ‘and the 20.2% of times that the outcome was not determined / inconclusive and the larger number of ‘no further action’ recorded. The Service Manager said there could be a number of reasons for this; for example a police action so not everything is known. Follow up action could also include training. The Independent Chair said the board are doing work to get an outcome that people want - making 'safeguarding personal ' is focused on this and trying to ensure that the victim is involved in the resolution of what can be intimate family relationships .

5.5 A member commented that last year’s annual report to the committee picked up on

concerns that there were no alerts from hospitals, and that this year there are some, but they are still very low. The CCG Director reported that the CCG are working with hospital on adult safeguarding training, which is not as embedded as children's safeguarding. Hospitals also have now got safeguarding leads. It will take time to bed down but there are action plans. The Independent Chair added that the board are getting all the partners round the table to do self assessment.

5.6 The member followed up by asking if the board had looked at comparison statistics for referrals from other hospitals, and enquired about the seniority and attendance at the board from hospitals and other partners. The Independent Chair commented that sometimes incidents can enter different processes, for example 'serious untoward incident', or a police process rather than getting flagged up as a safeguarding alert. She said that she had approached SlaM about the right level of representation on the board and there is also an issue with police participation in Vulnerable Adults Safeguarding Boards across London. She went on to comment that representation should be at the right level of seniority , and actually the board need a balance of personal with operational responsibilities and strategic influence: people do need to understand the detail.

5.7 A member enquired further about SlaM and the METS poor attendance and the Independent Chair said that she is waiting for a meeting with SlaM's medical director. The CCG director said that this is being pursued and the she predicts it will improve. The Independent Chair said so far she had not met anybody from the Police and there had been no representation at meetings; however she understands that is to do with staff changes and will change. She added that she also chairs the London safeguarding chair network so that is helpful in highlighting problems such as London wide problems with the METs engagement. A member commented that John Sutherland, the Southwark Borough Commander, is due back and is proactive.

5.8 A member raised concerns with the higher number of financial abuse cases. She asked for the reasons, and if more community awareness would help tackle the issue. The Independent Chair commented that this could be caused by a combination of the recession and social problems. She said there is a high awareness of financial abuse amongst professionals , but lower awareness amongst friends and family , and the board will be running a campaign 'Don't turn your back ' , which will be encouraging people to look out for each other . The CCG director said that the CCG we will be holding sessions on adult safeguarding awareness raising.

5.9 A member commented on the number of 'Deprivation of Liberty and he said he was reassured that 20 were authorised and 16 refused -, however he noted that the report commented that the Department of Health are saying more should be processed and he asked for clarification. The Independent Chair explained that given the high levels of dementia the board would expect more people to understand and use the procedure.

6. COMMISSIONING URGENT ACCESS TO PRIMARY CARE

6.1 Tamsin Hooton, Director of Service Redesign, SCCG, introduced the report on 'Extended Primary Care in Southwark'. She explained that the SCCG have been looking at modelling an extended GP access offer, consisting of hubs in each neighbourhood open 8am to 8pm. The engagement exercises with the community so far have demonstrated overall support for plans, with key messages received from people on location, transport, access needs for primary care and the importance of communication.

6.2 A member commented that there are rumblings that the Lister Walk In Centre will close. The Director of Service Redesign explained that there will be no formal notification until the third week of April, however the CCG are talking about the possibility of decommissioning this service. The focus is on encouraging GPs to be working collectively to participate in local hubs, the present Lister Walk In Centre will almost certainly be used, and again Dulwich Hospital is a likely location.

6.3 The Director of Service Redesign was asked if this will improve access and she responded that we are looking at more integrated access - so there is not the present disconnect with local practices , as with the Lister.

6.4 A member commented the paper talks about a model with either two or four hubs; he thought there should be a minimum of three, ideally four. She explained that there are cost implications, but four does sit with the CCG community plans, however there are issues with rotas and capacity.

6.5 The Director of Service Redesign was asked about waiting periods, and the member said that he is increasingly thinking that there should be a minimum waiting period to see a GP of 5 to 7 days. He voiced concern that people are saying they have to wait two or three weeks to a see a GP. Other members agreed and commented that their constituents had raised similar concerns.

6.6 Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group, responded by explaining that there is a London piece of work looking at developing standards. The London NHS 'Call for Action' talks about differential access - some people are prepared to wait for preferred doctors, while other people want to see any doctor soon. To do this practices will need to collaborate at a greater scale and the model proposed aims to deliver the change necessary.

6.7 A member asked to what extant Southwark can decide the standard of service. The CCG Chief Officer said that the CCG can offer extended services over and above the core standard - set by NHS England. He said it was important to engage with the 'Call for Action'.

6.8 A member pointed out sometimes that there is local conflict over the delivery of services, for example drug addiction services and needle exchange, and the role of pharmaceutical services.

6.9 The Director of Service Redesign was asked about SELDOC and she said there was a challenge bid to improve access, however this will be competitive, but even

if SELDOC do not receive the extra money the CCG will be meeting some recurrent costs to fund the initiative. Members emphasises the quality and importance of the SELDOC service.

7. SOUTHWARK CLINICAL COMMISSIONING GROUP (CCG) PERFORMANCE REPORT

7.1 Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group introduced the CCG performance report.

7.2 A member commented on the KCH 4 hour wait target performance going down marginally and concerns about possible downward drift and asked about a scheduled visit to the Emergency Department at Denmark Hill. The Chief Officer commented that they will be visiting soon, but Friday's planned visit was going to be rescheduled.

7.3 A member said that she had been told by the Ambulance Services personal that on occasions hospitals will not admit from ambulances for thirty minutes to protect the four hour target. The Chief Officer explained usually patients are allowed to wait 15 minutes before being admitted - however there are 'black breaches' where patients have to wait more than 60 minutes to be admitted to the Emergency Department. He explained that the targets for the Ambulance Service and the 4 hour target are there to manage this interplay. He commented that he did not think abuse of ambulance waiting times are common, but that on occasions he thinks it does happen. He reported that there had been 8 black breaches reported, which is not a huge amount. The most important issue is patient safety.

7.4 The Chief Officer was asked if the figures for Princess Royal University Hospital (PRUH) are going to effect the overall KCH performance targets. He explained that the SCCG have agreed that they will closely monitor the figures supplied for both emergency departments managed by KCH; Denmark Hill site and PRUH. The SCCG are the lead commissioner for KCH, but they are really judged and responsible for local residents. A member asked for assurance that figures will continue to be available on local performance. The Chief Officer commented that the KCH will be reporting nationally on top line figures for all their sites, however the CCG will be focusing strongly on local performance and ensuring it is closely monitored and does not get worse.

8. REVIEW : ACCESS INTO HEALTH SERVICES IN SOUTHWARK

8.1 The chair introduced the draft report, and reported that the CCG had been invited to make comments and as a result of this some of the text had been amended, and a revised draft tabled. The project manager, Julie Timbrell, explained that the CCG had provided updated information on the 111 service, in particular they had explained that the London Ambulance Service had been awarded the new contract and that they were amongst the top 5 providers nationally.

8.2 The chair invited member to make comments. A member said that he thought that recommendations 3, 8 and 9 should emphasise the role of the CCG, and the committee agreed. The chair recommended a further amendment to recommendation 13 following comments from the CGG and that Public Health look at the reasons for increased acuity. A member queried the centrality of the Health and Well-being Board to lead on this and the chair invited comment from the project manager, who said increased acuity could be seen as a system problem and that the board did have a role as a systems leader. She commented that Public Health had sited some papers at the last meeting on the causes, and Public Health has research capacity. The CCG agreed with the recommendation and with the amendment that Public Health undertakes further work into the underlying causes of increased acuity.

8.3 Members queried the capacity of the committee to understand the data. The project manager commented that the Department of Health are doing work on in relation to Francis Inquiry to provide benchmarking on ward staffing levels to help scrutiny of hospital performance and this will be helpful to scrutiny. The chair said that that a letter had been written to the Leader about more resources for health scrutiny and she will be chasing a response.

8.4 A further recommendation was suggested on offering a minimum standard for patients accessing a GP appointment. The committee agreed and the CCG advised waiting for the outcome of the NHS England's Call for Action.

RESOLVED

Recommendation 3, 8 & 9 will be changed to emphasis the role of the CCG.

Recommendation 21 will be made clearer and will describe the support that the council currently offer to assess blue badge applications.

Recommendation 13 will include the amendment that Public Health carries out a piece of research into the reasons behind the increased acuity in Southwark.

Recommendation 26 will include an amendment saying that Southwark will consider an offer that ensures minimum standards of access for patients in Southwark in regards to contact with a GP, if appropriate following NHS England's Call for Action response.

9. REVIEW : PREVALENCE OF PSYCHOSIS AND ACCESS TO MENTAL HEALTH SERVICES FOR THE BME COMMUNITY IN SOUTHWARK

9.1 The chair said that a draft report will come to the next meeting.

10. WORKPLAN

10.1 This was noted.

11. PAPERS FOR INFORMATION

11.1 The update paper from Healthwatch was noted.

NHS Southwark Clinical Commissioning Group

Introduction to NHS Southwark CCG

Healthy Communities Scrutiny Sub-Committee

June 2014

Contents

NHS Southwark Clinical Commissioning Group

Southwark CCG's role in the local NHS

NHS Southwark Clinical Commissioning Group

Commissioning

The money used to pay for NHS services is managed by commissioning organisations, which act to procure health services from provider organisations like hospitals or nursing homes. Since April 2013 Southwark CCG has been responsible for planning, procuring and managing the contracts of NHS and other providers delivering services to patients for:

- Most non-specialist hospital care (e.g. routine operations)
- Urgent and emergency care
- Rehabilitation care (e.g. physiotherapy services)
- Most community health services (e.g. district and school nursing)
- Mental health services and services for people with significant physical and learning disability

Quality Assurance

The central part of our role is to manage NHS contracts with the providers who treat patients in order to ensure that they are offering safe and high quality services. As an organisation made up of GPs and other health professionals, we are using our clinical expertise to ensure that the health services we pay for are available to patients without undue delay. In addition, we will work with NHS providers to see that patients using local services are achieving the best possible clinical outcomes.

Service Improvement

Where we learn that the NHS could be better we will work with providers of services to ensure improvements are made. We also work to redesign care pathways (the route from one service to another for patients with certain illnesses) so that they work effectively. We have planned a number of service improvements and redesign pathways for our first year and these are detailed in on the following pages.

The CCG is a membership organisation

NHS Southwark Clinical Commissioning Group

- The CCG is a membership organisation made up of the 45 GP practices in Southwark.
- The CCG works as an organisation that is clinically-led and situated close to patients and our communities.
- CCG member practices play a role to achieve the best possible health outcomes for their practice population and through their contribution to the work of the CCG, for the population of Southwark as a whole.

Member Practices – advocate for their practice population, and also have a range of roles whilst being members of the CCG:

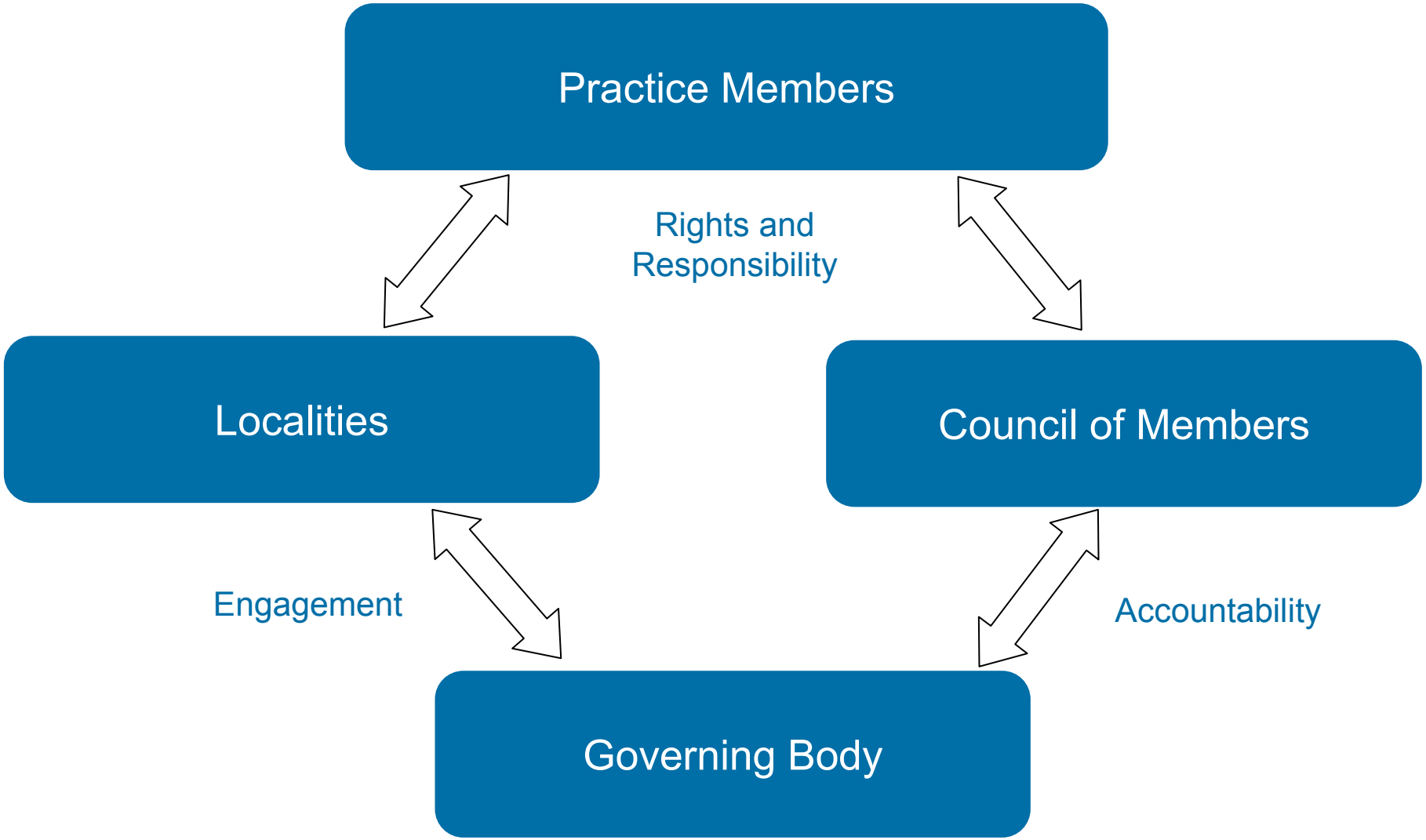
- Deliver care
- Coordinate care
- Provide clinical expertise
- Gate-keep for the system

CCGs – advocate for the system, ensuring:

- Quality, safety & improvement
- Value
- Equity
- Accountability
- Sustainability

Structure of the membership organisation

NHS Southwark Clinical Commissioning Group



The CCG mission and vision

NHS Southwark Clinical Commissioning Group

Mission: The CCG's mission – or overarching purpose – is to commission high quality services that improve the physical and mental health and wellbeing of Southwark residents and result in a reduction in health inequalities. The CCG will ensure commissioning for our population will be:

- Evidence-based
- Focused on clinical outcomes and high quality standards of care
- Led by local frontline healthcare professionals
- Determined by local need
- Informed by genuine patient and public engagement
- Result in more information and choice for patients

Vision: The CCG will work to achieve the best possible health outcomes for Southwark people. The vision for services commissioned on behalf of Southwark's population is that they function to ensure:

- People live longer, healthier, happier lives no matter what their situation in life
- The gap in life expectancy between the richest and the poorest in our population continues to narrow
- The care local people receive is high quality, safe and accessible
- The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
- We make effective use of the resources available to us and always act to secure the best deal for Southwark

Our values

NHS Southwark Clinical Commissioning Group

Values

- Guided by the founding principle of the NHS: good healthcare available, free at the point of delivery
- Places patients, health improvement and quality at the heart of everything we do
- Is honest and open about the actions and decisions we take
- Remains accountable to the public and recognise our responsibility to act in their best interests
- Ensures our decisions are evidence based, fair and make best use of the resources we have available
- Acts responsibly as a public sector organisation and remain committed to working in partnership.

CCG responsibilities – a summary

NHS Southwark Clinical Commissioning Group

What the CCG must do (with examples)

1. **Statutory responsibilities (e.g.)**
   - Ensure that all commissioned services are safe and of high quality
   - Safeguarding children, adults and people with learning disabilities
2. **NHS Constitution standards (e.g.)**
   - A&E 4 hour standard; 18 weeks RTT, cancer waiting times, IAPT coverage and outcomes
3. **NHS Operating Framework (e.g.)**
   - Ensure commissioned providers meet specific national standards (e.g. rates of *c.difficile* and MRSA infection; rates of dementia diagnosis)
   - Act to improve a number of mandated population-wide outcome indicators (e.g. rate of emergency admissions).

What the CCG has chosen to do (with examples)

1. **Southwark Primary and Community Care Strategy and neighbourhood development model.**
2. **Work with partners and stakeholder to commission integrated care pathways to enhance admission avoidance and improved hospital discharge (e.g. SLIC)**
3. **Commission pathways for patients referred with common health conditions (e.g. diabetes; respiratory illness; CVD)**
4. **Re-procurement of psychological therapies pathway to deliver effective holistic services to patients.**

What the CCG must do

NHS Southwark Clinical Commissioning Group

- CCGs must secure 'continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness' (Health & Social Care Act, 2012: 14R).
- Act as the lead commissioning organisation for King's College Hospital NHS Foundation trust; and as co-commissioner for Guy's & St. Thomas' and South London and Maudsley FTs.
- Support NHS England to enhance the quality of primary and community care services.
- Ensure that all commissioned services meet quality and safety standards (e.g. rates of c.difficile and MRSA infection; rates of dementia diagnosis).
- Securing NHS Constitution standards on behalf of Southwark patients (e.g. A&E 4 hour standard; 18 weeks RTT, cancer waiting times, IAPT coverage and outcomes).
- Achieve financial balance.
- Ensuring commissioned providers and the CCG act to improve a number of mandated population-wide outcome indicators (e.g. potential years of life lost to causes amenable to healthcare; rate of emergency admissions; patient experience of GP services; % of patients with LTCs who feel supported to manage their health).
- Establish a clear forecast of anticipated levels of commissioned activity at all hospital providers accessed by our patients.
- Identifying incidence of and learning from Never Events, serious incidents; healthcare acquired infections.
- Safeguarding children, adults and people with learning disabilities.

What the CCG has chosen to do

NHS Southwark Clinical Commissioning Group

- Together with Southwark Local Authority, commit to making the integration of services a primary aim of service transformation. We are a partner organisation in Southwark and Lambeth Integrated Care (SLIC) programme.

- Commission for services 7-days-a-week in collaboration with Southwark local authority and NHS England commissioners to support admission avoidance and to improve discharge from hospital. Oversee extension of '@home' admission avoidance programme including full roll-out across Southwark and integration with supported discharge.

- Prioritise the development of future-focused primary care models of care in the borough, delivered through the implementation of the Southwark Primary and Community Care Strategy and neighbourhood development model. The local authority is a key stakeholder in this programme.

- Continued implementation of the service model for the Dulwich locality and implementation of community hub model across the borough.

- Commission extended access to primary care across the borough – Prime Minister's Challenge Fund.

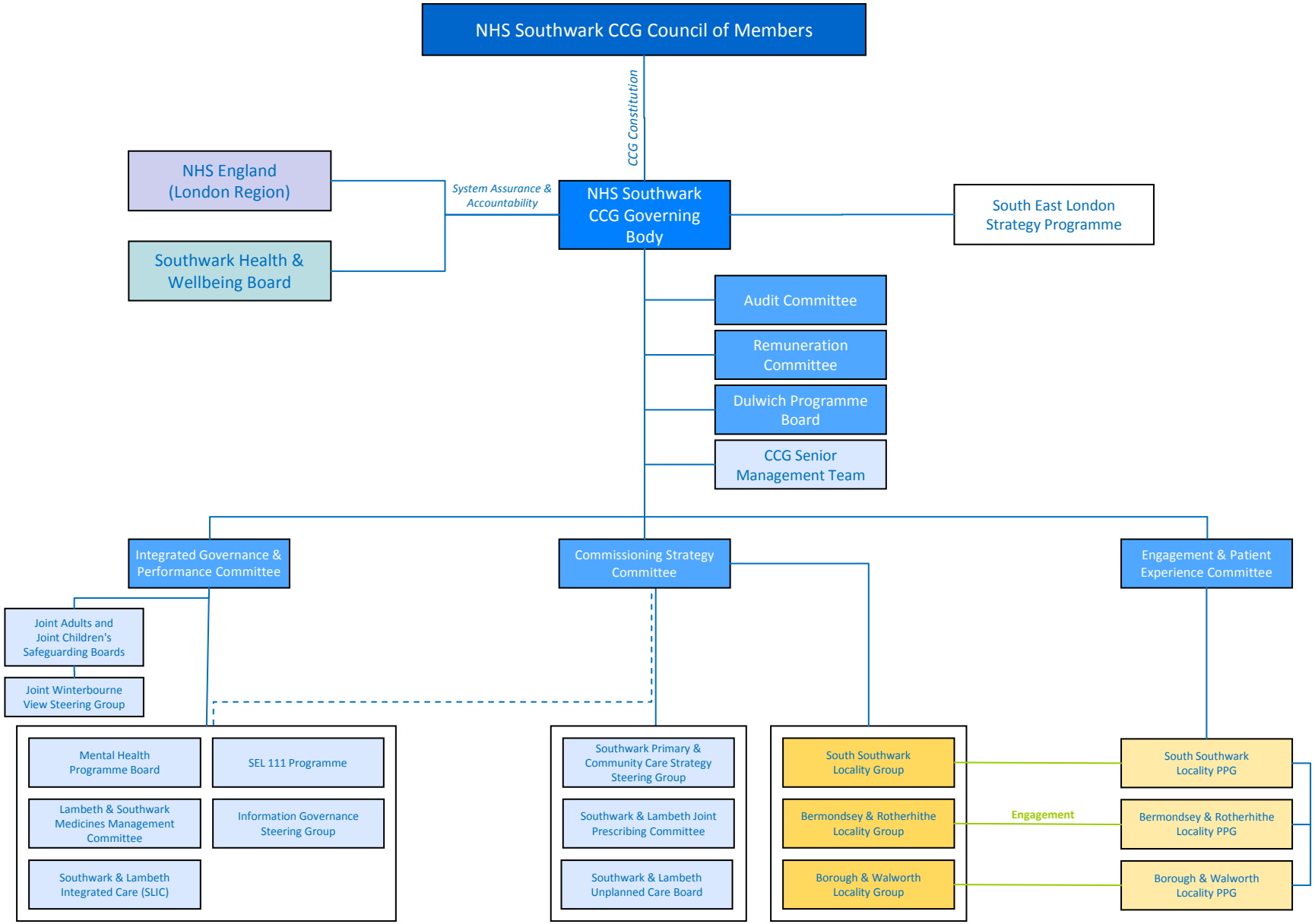
- Commission enhanced primary care support to Southwark care homes operating as part of a specialist multi-disciplinary model of care for patients living in residential accommodation.

- Commission pathways for patients referred with common health conditions (e.g. diabetes; respiratory illness; gynaecology) to specialist services provided in community facilities in different locations of the borough.

- Re-procurement of psychological therapies pathway, to deliver effective and high quality services that treat people holistically, taking account of their mental health, physical health and social needs.

CCG governance structure

NHS Southwark Clinical Commissioning Group



The CCG Governing Body

NHS Southwark Clinical Commissioning Group

Clinicians – voting

8 GP clinical leads
(includes 1 job share)

2 nurse members:

1 practice nurse

1 external nurse
(statutory requirement)

1 external secondary care doctor
(statutory requirement)

1 public health doctor

TOTAL = 12

Non-clinical - voting

3 Lay members

1 Chief Officer

1 Chief Financial Officer

1 Healthwatch Representative

(All above are statutory requirements)

TOTAL = 6

Non-clinical – non voting

1 Director of Service Redesign

1 Director of Client Group Commissioning

1 LMC Representative

1 Local Authority Representative

1 Local Secondary Care Doctor

CCG management structure

NHS Southwark Clinical Commissioning Group

Finance and Membership	Integrated Commissioning	Quality and Performance
Approx. 10 WTE	Approx. 15 WTE	Approx. 15 WTE
Finance Corporate Administration Corporate Governance CSU Contract Management Patient and Public Engagement Membership Engagement SIRO / Information Governance Procurement EPRR	Acute Care Primary and Community Care Mental Health Cancer Maternity Children's Analytics	Quality and Clinical Governance Provider Performance Combined Safeguarding Continuing Care Caldicott Guardian Infection control Organisational Development Medicines Management

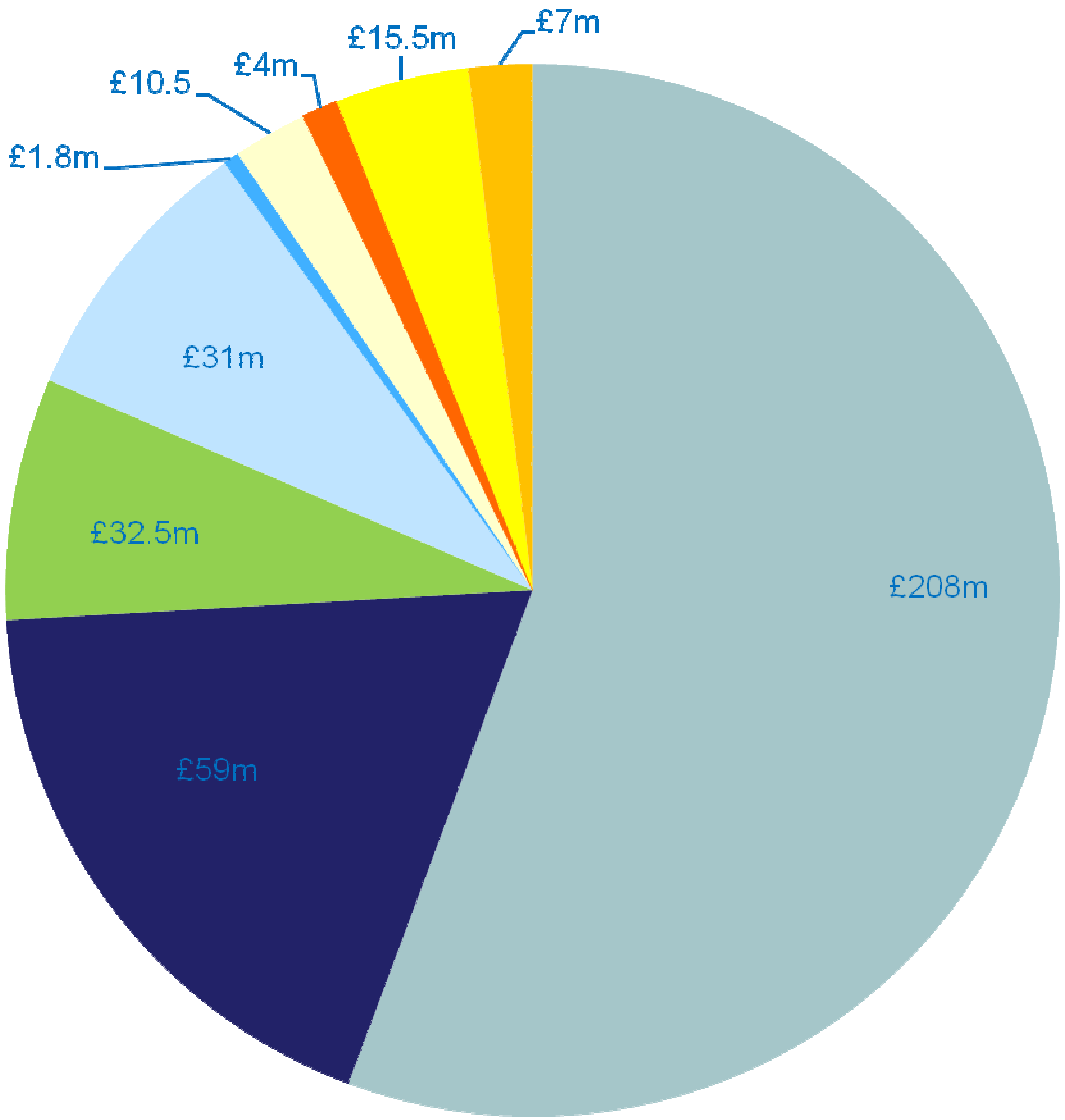
CCG Financial Position for 2014-15

NHS Southwark Clinical Commissioning Group

- Against this the CCG faces significant acute contract cost pressures from increased demand, population growth, and increased mental health pressures.
- Inflation is predicted to increase in the future and beyond 2015-16 it is likely that the CCG will only receive an annual increase of less than 2% per year.
- Our local population is growing at 1.7% or more per year, which will increase the demand for services across all services.
- The CCG will receive an increase of 3.5%, just over £12m in 2014-15 and a further 2.7% in 2015-16.
- There are a range of identified investment proposals to be considered by the CCG Governing Body in 2014/15.
- The CCG has an efficiency target of approximately £15m for 2014-15. This is to be delivered together with commissioned providers, through a range of programmes of service change and productivity improvement initiatives.

The CCG Budget 2014/15

NHS Southwark Clinical Commissioning Group



- Acute hospital services
- Mental health and learning disability services
- Community services
- Primary care prescribing
- Re-ablement fund with Southwark Local Authority
- Continuing care and funded nursing care
- Property and other costs
- In year reserves and risk-management fund
- CCG running costs (corporate overheads)

Total = £369m

CCG Performance

NHS Southwark Clinical Commissioning Group

Performance Improvements

1. All cancer waiting times targets achieved for Southwark patients in 2013/14.
2. Rate of dementia diagnosis improved in 2013/14 compared to previous year and national target achieved. Performance has continued to improve in 2014/15.
3. The number of Southwark patients in mixed sex hospital wards is zero to date in 2014/15.
4. Attendances and admissions of Southwark patients at King's reduced/stabilised in the face of growth elsewhere
5. More people with severe mental health conditions with better coordinated care under the Care Programme Approach. National target achieved for 2013/14.
6. CCG *c.difficile* infection rate standards delivered in 2013/14.
7. An increased proportion of patients on COPD registers have been supported to quit smoking.
8. Improved outcomes for Southwark patients with diabetes through work with the Diabetes Modernisation Initiative.
9. More patients on end of life care pathways are registered on 'Coordinate My Care' system and supported by their GP to ensure they benefit from good care and are supported to die in accordance with their preferences.

Current Performance Challenges

1. King's is currently exceeding national standards for elective waiting times. The target is that 90% of patients should wait no longer than 18 weeks from the date of their referral to the beginning of their elective treatment. The CCG has agreed a detailed action plan with the trust to address this area of performance.
2. King's A&E department at Denmark Hill is not consistently achieving the requisite 4 hour standard that 95% of patients are admitted or discharged within four hours of arrival at A&E. The CCG and other stakeholders have agreed a detailed action plan with the trust to address this area of performance.
3. The CCG did not consistently achieve the national access to psychological therapies standard in 2013/14 for patients referred with anxiety and/or depression. The target is that 12.5% of patients predicted to have these conditions are seen by appropriate services each year. The CCG has made significant investment in this area in 2014/15.

NHS
Southwark
Clinical Commissioning Group

Appendix A

CCG Priorities and Partnerships

Working with people and stakeholder organisations

NHS Southwark Clinical Commissioning Group

Member practices

- The CCG is its membership and the member practices are the CCG.
- Practices are advocates of their local population with a focus on improving care quality and outcomes.
- Dispersed leadership model.
- Localities forums to engage in and shape decision-making, implementation and delivery.
- The CCG established the Council of Members.

Patients and the public

- Network of Patient Participation Groups (PPGs) across all practices in Southwark to capture patient views on the quality of local services.
- Locality patient participation groups with representatives on Engagement & Patient Experience Committee (EPEC), which feeds into the Governing Body.
- Other engagement through *Call to Action*; community meetings; online community forums; borough wide workshops.

Partners

- With CCG, provider and social care organisations on the Southwark & Lambeth Integrated Care Programme.
- With Southwark Council on Southwark Health & Wellbeing Strategy; Better Care Fund; Primary & Community Care Strategy.
- With NHS England on the improvement of primary care quality, specialised commissioning and pan-London programmes of development.
- Partner organisations in health and social care across south east London to deliver the Five Year Strategic Plan for South East London.
- With *Healthwatch Southwark*, the patient and public voice champion for Southwark.

Working with member practices

NHS Southwark Clinical Commissioning Group

- The CCG is its membership and the member practices are the CCG.
- Practices recognised as best advocates of their patients and the population of Southwark.
- Dispersed leadership, with decision making and delivering for patients effectively delegated and devolved to ensure the local commissioning of services is effective.
- Primary role of member practices in relation to the CCG is to ensure that the system delivers the best possible health outcomes for their practice population.
- Practice Localities provide forums for member practices to engage in and shape decision making, implementation and delivery in-year and for future years. That work is taken forward by the Governing Body on their behalf.
- The CCG established the Council of Members to allows the membership to:
- Hold the Governing Body and members to account for delivery
- Agree the CCG Constitution and any changes to it
- Consider and agree CCG operating and strategic plans
- Ensure the processes we have established are followed

Membership Governance, Leadership & Engagement

NHS Southwark Clinical Commissioning Group

Governance

NHS England

Council of Members

The CCG is accountable to the Department of Health via NHS England (NHSE) for delivery of statutory and national requirements and our locally agreed plans

The CCG's Council of Members allows the membership to discharge four functions to:
1.Agree the CCG Constitution and any changes to it
2.Consider and agree CCG operating and strategic plans
3.Hold the Governing Body and members to account for delivery
4.Ensure the processes we have established are followed

Leadership and Delivery

Governing Body

The Governing Body receives a national (NHSE) and local (CoM) mandate and is required to lead the development and delivery of commissioning plans. In receipt of that mandate it is required to engage the membership through localities and interaction and representation through clinical leads in securing high quality services from current commissioned services and to plan and enact agreed changes to future services

Membership Engagement

Locality | Locality | Locality

Practice | Practice | Practice | Practice

Practice responsibilities

Practice Populations

Localities provide forums for member practices to engage in and shape decision making, implementation and delivery in-year and for future years. That work is taken forward by the Governing Body on their behalf

As commissioners – member practices are advocates of their patients in the commissioning process – ensuring their front line experience of knowledge of the local system shapes its future

Working with patients and the public

NHS Southwark Clinical Commissioning Group

- CCG has established a network of Patient Participation Groups (PPGs) across all practices in Southwark. The role of the PPGs is to capture patient views on the quality of local services.

- Practice patient representatives attend one of four locality patient participation groups. Each of these groups then nominates two representatives to sit on the Engagement & Patient Experience Committee (EPEC) which feeds into the Governing Body.

- Engagement through the PPG engagement structure; the CCG's flagship Call to Action event on 22 October 2013, attendance at community meetings; via online community forums; and through borough□wide workshops.

Key messages from recent patient and public feedback:

- More services located in community neighbourhood settings and to be accessible both in terms of when they are open and where they are located
- Support for enhanced self-management programmes and information
- Further actions to deliver a programme of preventative care to support people to stay healthy
- Better interface and communication between primary and secondary care, including smoother system for discharge from hospital
- Better alternative services to A&E for people in crisis
- A greater focus on physical health for people with mental health conditions

Working with our partners and stakeholders

NHS Southwark Clinical Commissioning Group

To successfully deliver our plans the CCG needs to act with partners and stakeholders. The CCG works as a partner in the following programmes and areas of business:

1.With King's Health Partners; Southwark Council; Lambeth Council; Lambeth CCG; local primary care providers and other associated organisations on the development of models of care as part of the Southwark & Lambeth Integrated Care Programme.

2.With Southwark Council to deliver improved outcomes for local residents through delivery of the Southwark Health & Wellbeing Strategy; Better Care Fund; Primary & Community Care Strategy key joint transformational programmes of work such as the Joint Carers Strategy.

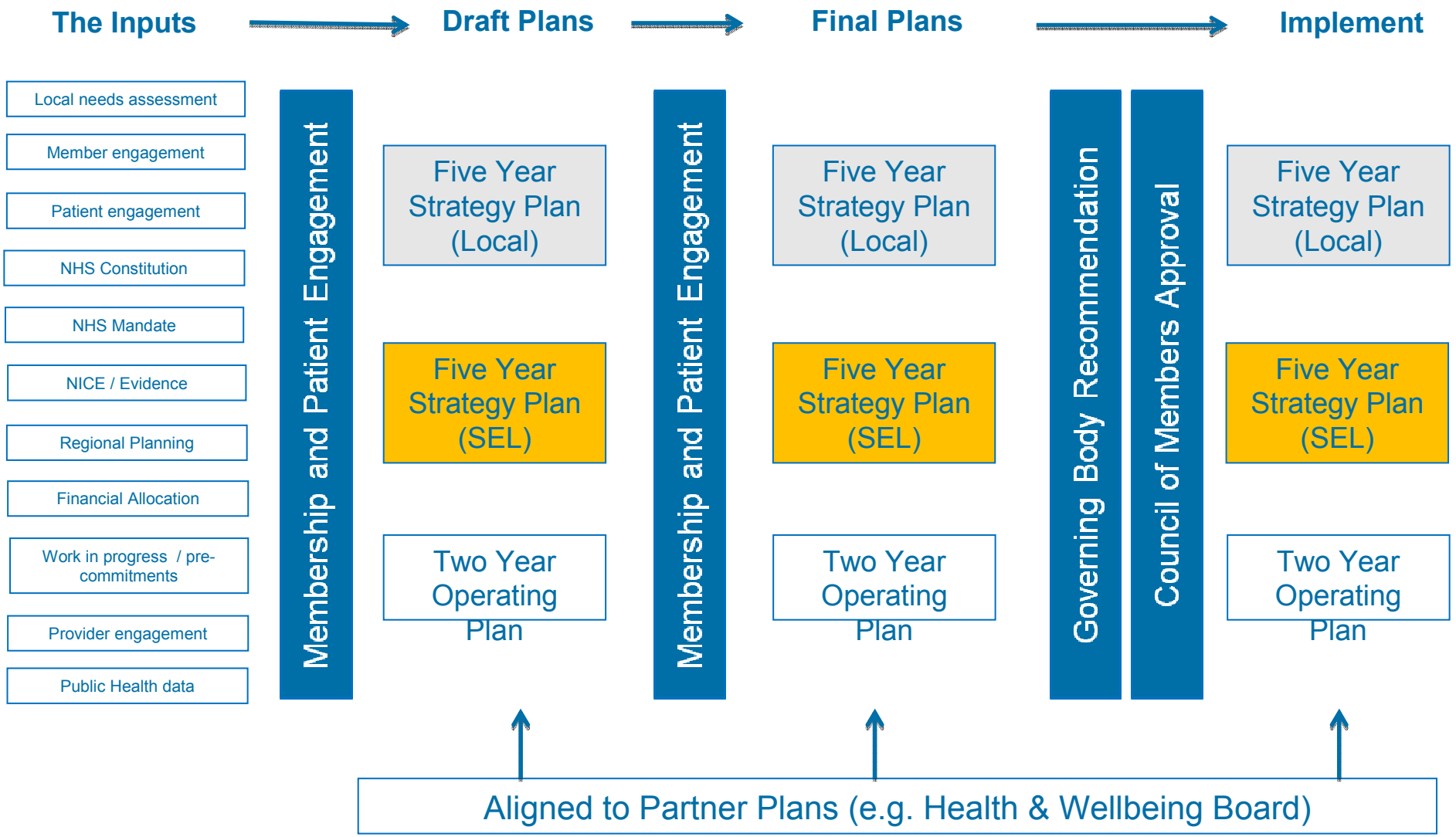
3.With NHS England on the improvement of Primary Care quality, specialised commissioning and pan-London programmes of development.

4.Partner organisations in health and social care across south east London to deliver the 5 Year Strategic Plan for South East London.

5.Healthwatch Southwark, the patient and public voice champion for Southwark, also sits on the Governing Body and a number of committees including the Commissioning Strategy Committee & the Integrated Performance and Governance Committee.

Planning and securing local alignment

NHS Southwark Clinical Commissioning Group



South east London five year commissioning strategy

Update on progress for Southwark Healthy Communities Scrutiny Sub-committee

25 June 2014

The content of this presentation reflects work in progress and is subject to change following wider engagement

What is the five year strategy?

- A new 5 year commissioning strategy for health and integrated care across south east London
- To improve health services for everyone in Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark
- Addressing issues that cannot be solved by one area alone or where there is more that can be achieved by working together
- Five years gives everyone time to think about, agree and make the improvements needed and build on what already works well and suggest what needs to be improved
- Building on borough-level Joint Strategic Needs Assessments, commissioning plans and health and wellbeing strategies , which will continue to be produced to identify borough-specific issues and challenges and the local plans to address them
- Significant engagement is being undertaken to obtain the views of local people across south east London

Who is involved?

- Six NHS organisations (Clinical Commissioning Groups) in south east London
- NHS England (London) commissioners
- Shaped by seven Clinical Leadership Groups (CLGs)
- In close partnership with local authorities, providers of care and other partners
- Patient and public voices

Our case for change

Health outcomes in south east London are not as good as they could be:

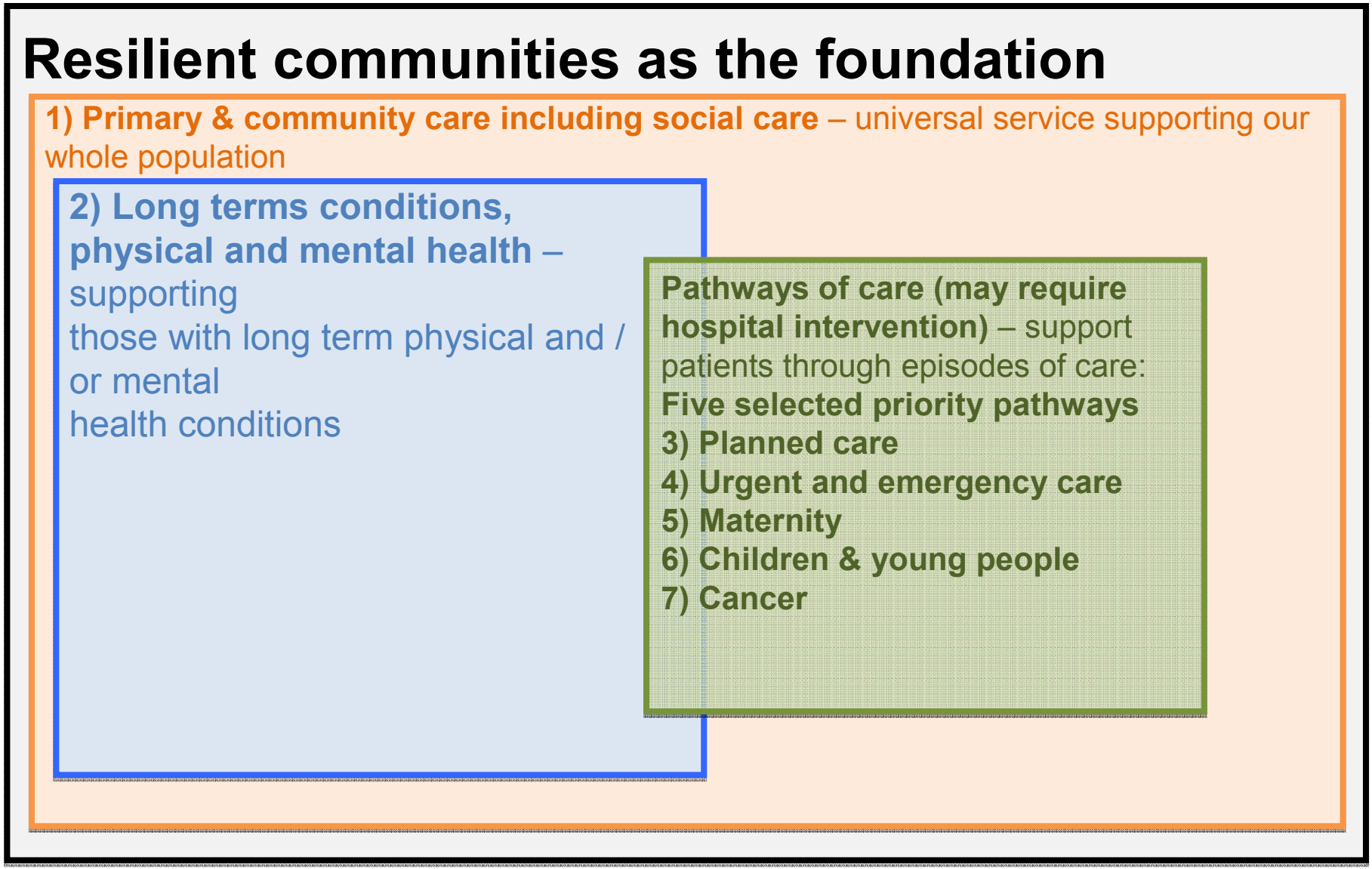
- Too many people live with preventable ill health or die too early.
- The outcomes from care in our health services vary significantly and high quality care is not available all the time.
- We don't treat people early enough to have the best results.
- People's experience of care is very variable and can be much better.
- Patients tell us that their care is not joined up between different services.
- The money to pay for the NHS is limited and need is continually increasing.
- It is taxpayers' money and we have a responsibility to spend it well.

The longer we leave these problems, the worse they will get; we all need to change what we do and how we do it.

Our vision and ambition

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste

Proposed integrated system model



Proposed integrated system model

- Brings together the different components of the strategy into a proposed single system focused on delivering the objectives of the strategy.
- Recognises that we must and can strengthen the resilience of our local communities.
- Primary and community care services are the cornerstone of health and social care. 90 per cent of NHS contacts take place in the community.
- People with long term physical and/or mental health conditions need integrated teams which bring together social care and wider local authority services, NHS funded services and the voluntary sector.
- People who require care need different parts of the system to be well connected so that their care is joined up
- In addition to primary and community care and long term conditions - physical and mental health, there are a further five priority pathways which support people across hospital and community settings:
  - planned care
  - urgent and emergency care
  - maternity
  - children & young people
  - cancer

This is a clinically-driven strategy

There are seven Clinical Leadership Groups developing the strategy:

- Primary and community care
- Long term conditions - physical and mental health
- Planned care
- Urgent and emergency care
- Maternity
- Children and young people
- Cancer

The groups include clinicians and senior experts from south east London's NHS commissioners, providers of NHS services, social care services, public health services, Healthwatches and patient and public voices

They have developed early proposed new service models for testing and engagement

Overview of our work to date

The following have been engaged in planning, discussion, design, challenge and learning:

- **More than 100 clinicians**
- **Over 200 patients, members of the public and Healthwatches**
- **Clinical commissioners and senior management from all six CCGs**
- **NHS England primary care and specialised teams**
- **All six local authorities including Health and Well-Being Boards (to April 2014), CEOs, public health and social care**
- **Members of the voluntary sector**
- **Chief executives, medical and nursing directors from local providers of NHS services**

This builds on engagement and strategy/ planning work within individual boroughs

A south east London Case for Change has been developed, on which we have carried out further engagement and which has been used to set the priority areas of focus for the strategy

An overarching proposed integrated service model has been developed

GP practices are working together in Local Care Networks

Proposed new models of service delivery have been designed by Clinical Leadership Groups and these will now be tested through wider engagement with clinicians and local people and refined before detailed planning to implement is put in place.

Implementation work already underway

We understand the urgency to improve services and significant work is already underway to deliver parts of the strategy during years one and two.

CCG operating plans set out a series of bold changes that will be delivered in years one and two of the strategy, and we have begun the process of evaluation and continuous improvement for these services.

Some examples of significant work already being implemented include:

- **Development of wider primary care, provided at scale**
- **Developing a modern model of integrated care**
- **Improving and enhancing local urgent and emergency care**
- **Transforming specialised services**
- **Building resilient communities**
- **Partnership working across south east London**
- **Promoting public health role and prevention**

Further development from July 2014

Beyond 20 June 2014 our work will be focused on:

- Continued development of the integrated system model and the components that underpin it (models for primary and community care and long term conditions, plus our five priority pathways)
- Continued delivery of implementation work already underway (for example, development of wider primary care provided at scale; development of integrated services for people with long term conditions)
- July to December 2014 and beyond – Work to develop proposed interventions and impacts with considerably wider engagement with stakeholders on the strategy and implications as they develop

Agenda Item 6

OVERVIEW AND SCRUTINY TRIGGER TEMPLATE

Proposed Service Moves:

- **Transfer of elective adult inpatient orthopaedics from Denmark Hill & Princess Royal University Hospital (PRUH) to Orpington Hospital**
- **Transfer of elective inpatient gynaecology from Denmark Hill to PRUH**
- **Transfer of non-complex cataract surgery from Denmark Hill and PRUH to Queen Mary's Hospital (QMH)**

NHS Trust or body & lead officer contacts:	**Commissioners e.g. CCG, NHS England, or partnership. Please name all that are relevant , explain the respective responsibilities and provide officer contacts:**
King's College Hospital NHS Foundation Trust **Lead:** Roland Sinker, Chief Operating Officer	NHS Southwark CCG - Acting as Co-ordinating Commissioner on behalf of: NHS Southwark CCG NHS Lambeth CCG NHS Lewisham CCG NHS Bromley CCG NHS Bexley CCG NHS Greenwich CCG **Lead:** Andrew Bland, Chief Officer

Trigger	**Please comment as applicable**
1 Reasons for the change & scale of change	
What change is being proposed?	1. All **elective inpatient orthopaedic** activity, with the exception of paediatrics, limb reconstruction and complex procedures to be transferred from Denmark Hill and PRUH to Orpington Hospital. NB. The full range of clinics, day surgery, rapid access and 24 hour access to emergency orthopaedic services will remain at both Denmark Hill and PRUH. 2. Transfer of **elective inpatient gynaecology** from Denmark Hill to PRUH NB. The full range of clinics, day surgery, ambulatory and 24 hour access to emergency gynaecological services, including those connected to early pregnancy, will remain at Denmark Hill 3**.** All **non-complex cataracts** currently undertaken at Denmark Hill and PRUH to be transferred to an expanded King's cataract facility at Queen Mary's Hospital, Sidcup NB. All ophthalmology clinics, complex cataract surgery, other

	ophthalmology related surgery and access to emergency ophthalmology services will remain at Denmark Hill and PRUH. As is currently the case, all patients will still have choice over their provider and place of treatment, including the choice to have their inpatient care at Denmark Hill if they wish to do so, and KCH have committed to accommodate this choice for all patients following the service moves. Commissioners and the Provider are committed to ensuring patients and referring clinicians are informed about their choice and how to exercise it, both at the point of initial referral to outpatient services and at the point that surgery/a procedure is decided upon.
Why is this being proposed?	These three service moves are part of the Trust's plan to address the current shortfall in capacity at the Denmark Hill and PRUH sites. The Trust is facing significant challenges across the whole range of services. Demand for both secondary and tertiary services continues to grow, and the emergency care pathway in particular is under constant pressure, with emergency bed requirements at both Denmark Hill and the PRUH at record levels. For some time now we have battled to support the increasing number of emergency admissions, balancing that against elective and tertiary work. However, the emergency growth over the last two years has resulted in very high bed occupancy levels at both the acute sites and the emergency growth has continued in 2014/15. Our current position is unsustainable in the long-term, therefore it is vital that we review our current model of service delivery and reorganise services to maximise utilisation of capacity across the Trust. By making these changes we will also be able, not only to address the referral to treatment back log, but also ensure that elective work is carried out as planned with minimal cancellations, thereby improving patient experience. **Elective inpatient orthopaedics & gynaecology** These moves will improve access to elective inpatient orthopaedic services and elective inpatient gynaecology services whilst releasing bed and inpatient theatre capacity at Denmark Hill and PRUH to support emergency demand and RTT (referral to treatment) pressures in other specialties which need to remain on site. Benefits of the moves include: ▪ A protected elective orthopaedic facility at Orpington and protected elective gynaecology facility at PRUH resulting in zero cancellations due to emergency pressures. ▪ Ability to make productivity improvements in both services e.g. an increase in the number of cases per list and a reduction in length of stay. This will help address the current RTT backlog. ▪ Releases elective beds at Denmark Hill, enabling the

	emergency bed pool to increase, this will help: o Reduce the number of Emergency Departments admitted breaches, o Reduce the time patients wait to be admitted from the 'decision to admit' o Speed up the turnover of cubicles in 'Majors' areas of the Emergency Department thus enabling other patients to be assessed quicker. **Non-complex cataract surgery** This move releases day case theatre capacity at both Denmark Hill and PRUH which will be used to help reduce the demand for inpatient beds. Released day case capacity at PRUH enables: ▪ Elective inpatient activity that is suitable for day surgery to move to day surgery ▪ The creation of rapid access lists in Day Surgery Unit to reduce emergency admissions in general surgery, gynaecology, T&O and urology Released day case capacity at Denmark Hill enables: ▪ Rapid access operating lists to be established to support emergency ophthalmology pathways. ▪ Ophthalmology to have access to sufficient Day Surgery Unit lists to meet demand and ensure RTT targets are delivered ▪ An increase in rapid access lists for other specialties which reduces their demand for emergency beds
What stage is the proposal at and what is the planned timescale for the change(s)?	**Elective inpatient orthopaedics** The Trust has been running elective orthopaedic services at Orpington Hospital since October 2013. Some Denmark Hill work has been undertaken there as a pilot to reduce waits. During Quarter Four 2013/14, 114 patients from Denmark Hill had their surgery at Orpington. [Southwark = 40, Lambeth = 38, Lewisham = 11, Greenwich = 6, Bromley = 5, Croydon = 3, Bexley = 2 and Other = 9] The Trust is proposing to move the majority of the remaining elective inpatient orthopaedics to Orpington in July 2014. The majority of the PRUH's elective orthopaedic activity is already undertaken at Orpington [NB. prior to October this work was undertaken at Queen Mary's Hospital], it is envisaged that there could be a further small increase. **Elective inpatient gynaecology** An initial pilot has been running since February 2014, where two lists a week have been moved from Denmark Hill to the PRUH. The Trust is proposing to move all elective inpatient gynaecology

	operating lists from Denmark Hill to the PRUH in July 2014. **Non-complex cataract surgery** This proposal is at planning stage. The Trust is working towards moving the non-complex cataract activity from Denmark Hill and PRUH to QMH in November 2014.
What is the scale of the change? Please provide a simple budget indicating the size of the investment in the service and any anticipated changes to the amount being spent.	There will be no additional cost to commissioners associated with these service moves
How do you plan to consult on this? (please briefly describe what stakeholders you will be engaging with and how). If you have already carried out consultation please specify what you have done.	**General** We have presented our proposals to the six south east London CCGs and they are supportive of these moves, on the basis patients are offered a choice of site including Denmark Hill and the PRUH and that the long term use of Orpington is subject to commissioner review in September 2015, with implementation of any changes to the use of the Orpington site by September 2016. The trust has also held two stakeholder meetings, one at Denmark Hill and one at the PRUH. The events were attended by commissioners, Trust governors, local authorities, voluntary sector organisations and patients. These service moves were presented at both events and supported by attendees. The trust has also met with local Healthwatch colleagues from Lambeth, Southwark and Bromley to discuss these proposals. The Trust will work with patients to ensure that we provide appropriate information about the changes. We will also conduct a short survey to seek the views of a cohort of patients who have used the services so that we can understand what went well and where we may need to make improvements. The Trust will continue to listen to patients and will monitor their experience through the trust's 'How Are We Doing Survey' and the 'Friends and Family Test'. This will provide invaluable information to inform on going service improvements. If a patient is unwilling or does not choose to have their procedure undertaken at the Trust's preferred site for all three proposed service moves, arrangements will be made to make bed and theatre capacity available to enable the patient to remain at their initial site where there will still be an element of elective work undertaken. **Elective inpatient orthopaedics** For those patients who were already on a waiting list when the opportunity to have their orthopaedic procedure at Orpington Hospital arose, they were contacted and informed about the new service. Patients were assured they would still be operated on by the existing consultant, asked if they would be willing to have their treatment undertaken at Orpington and then offered a date

	convenient for them. Orthopaedic patients are now being informed about the choices available to them for their inpatient treatment, including the inpatient service the Trust is running at Orpington Hospital by their consultant at the point they are being added to an inpatient waiting list. Patients will be able to have their treatment at Denmark Hill and PRUH if they choose to do so, although as a result of the capacity pressures at both sites waiting times are likely to be longer for those exercising this option. We have been monitoring patient experience regarding the orthopaedic pilot at Orpington: ▪ "How Are We Doing" survey in April 2014 had an overall score of 92 (above the benchmark of 86 and the elective orthopaedic ward at Denmark Hill which scored 90) ▪ Friends and Family score in April was 80.4. ▪ There have been no patient complaints since the orthopaedic service commenced at Orpington in October 2013, no infections and the handful of patients who had an unexpected deterioration in their condition were safely transferred to the PRUH. ▪ The service provides holistic care with a strong physiotherapy presence providing enhanced recovery resulting in short lengths of stay **Elective inpatient gynaecology** For those patients who were already on a waiting list when we commenced the pilot to move a few lists to PRUH they were contacted and it was explained this new service existed. Patients were assured they would still be operated on by the existing consultant, asked if they would be willing to have their treatment undertaken at PRUH and then offered a date convenient for them. Gynaecology patients will be informed about the choices available to them for their inpatient treatment at the point they are being added to the waiting list. Patients will be able to have their treatment at Denmark Hill if they choose to do so, although as a result of the capacity pressures waiting times are likely to be longer for those exercising this option. We have been monitoring patient experience regarding the gynaecology pilot: ▪ The "How Are We Doing" survey in April'14 had an overall score of 87 (above the benchmark of 86) ▪ The Friends and Family score in April was 78.6 with many positive comments
2 Are changes proposed to the accessibility to services? Briefly describe:	
Changes in opening times for a service	The change in location of elective inpatient orthopaedics, elective inpatient gynaecology and non-complex cataract surgery, will not

	result in any change to opening times for any aspect of these services.
Withdrawal of in-patient, out-patient, day patient or diagnostic facilities for one or more speciality from the same location	No services are being withdrawn.
Relocating an existing service	**Elective inpatient orthopaedics** Denmark Hill patients will have all outpatient appointments both pre & post-surgery and pre-assessment at Denmark Hill. They will only go to Orpington for their elective inpatient orthopaedic surgery. PRUH patients also attend Orpington for their pre-assessment. **Elective inpatient gynaecology** Patients initially referred to Denmark Hill will have all outpatient appointments both pre & post-surgery and pre-assessment at Denmark Hill. They will only go to the PRUH for their elective inpatient surgery. **Non-complex cataract surgery** Patients initially referred to Denmark Hill or PRUH will have all outpatient appointments both pre & post-surgery and pre-assessment at Denmark Hill or PRUH. They will only go to QMH for their cataract surgery
Changing methods of accessing a service such as the appointment system etc.	No change to accessing services
Impact on health inequalities across all the nine protected characteristics - reduced or improved access to all sections of the community e.g. older people; people with learning difficulties/physical and sensory disabilities/mental health needs; black and ethnic minority communities; lone parents. Has an Equality Impact Statement been done?	Patients will be assessed regarding need, for example those with learning disabilities, or older people will be assessed on a case by case basis. An equality impact assessment has been completed. In terms of access, the changes will provide an overall reduction in current wait times for patients. Transport will be provided for Lambeth, Southwark and Lewisham patients.
3 What patients will be affected? (please provide numerical data)	**Briefly describe:**
Changes that affect a local or the whole population, or a particular area in the borough.	**Elective inpatient orthopaedics** Orthopaedic patients transferring from Denmark Hill to Orpington will predominately be affected in the boroughs of Southwark and Lambeth During Quarter Four of 2013/14 an average of 102 elective orthopaedic inpatients (excluding paediatrics, limb

	reconstruction and complex cases) were treated at Denmark Hill each month, this equates to 46% of the total elective inpatient and day case orthopaedic activity. The number of additional patients planned to move per month for each Borough is: Lambeth 27 Southwark 26 Greenwich 6 Lewisham 5 Bromley 5 Bexley 5 **Elective inpatient gynaecology** Gynaecology patients transferring from Denmark Hill to PRUH will predominately be affected in the boroughs of Southwark, Lambeth and Lewisham. During 2013/14 an average of 65 elective gynaecology inpatients were treated at Denmark Hill each month, this equates to 20% of the total elective inpatient and day case gynaecology activity. The number of additional patients planned to move per month for each Borough is: Southwark 22 Lambeth 16 Lewisham 10 Greenwich 3 Bromley 3 Bexley 1 **Non-complex cataracts** Cataract patients will predominately be affected in the boroughs of Bromley, Lewisham, Southwark and Lambeth During 2013/14, an average of 330 non-complex cataract cases per month were undertaken at Denmark Hill at PRUH No. of patients planned to move per month for each borough is: Bromley 150 Lewisham 65 Southwark 39 Lambeth 30 Greenwich 10 Bexley 10
Changes that affect a group of patients accessing a specialised service	1. Orthopaedic patients 2. Female patients (gynaecology service) 3. Cataract patients

Changes that affect particular communities or groups	N/A
4 Are changes proposed to the methods of service delivery? Briefly describe:	
Moving a service into a community setting rather than being hospital based or vice versa	These services are being moved to another hospital
Delivering care using new technology	N/A
Reorganising services at a strategic level	These three service moves fit with the Trust's overall strategic plan to improve Emergency and RTT performance at both Denmark Hill & PRUH. The transfer of the elective orthopaedic inpatient service to Orpington and elective inpatient gynaecology service to the PRUH will have a positive impact on performance at Denmark Hill as it will release elective beds enabling the emergency bed pool to increase. This will help: ▪ Reduce the number of Emergency Department admitted breaches ▪ Reduce the time patients wait to be admitted from 'decision to treat' ▪ Speed up the turnover of cubicles in Majors thus enabling other patients to be assessed quicker. The protected beds for the elective orthopaedic patients at Orpington and elective inpatient gynaecology patients at PRUH, means there are no risk of procedures being cancelled due to emergency admissions. **Non-complex cataracts** The transfer of non-complex cataracts from Denmark Hill and PRUH to Queen Mary's Hospital frees day surgery capacity at both Denmark Hill and PRUH. Released day case capacity at PRUH enables: ▪ Elective inpatient activity that is suitable for day surgery to move to day surgery ▪ The creation of rapid access lists in Day Surgery Unit to reduce emergency admissions in general surgery, gynaecology, T&O and urology Released day case capacity at Denmark Hill enables: ▪ Rapid access operating lists to be established to support emergency ophthalmology pathways. ▪ Ophthalmology to have access to sufficient Day Surgery Unit lists to meet demand and ensure RTT targets are delivered ▪ An increase in rapid access lists for other specialties which reduces their demand for emergency beds

Is this subject to a procurement exercise that would lead to commissioning outside of the NHS?	No
5 What impact is foreseeable on the wider community? Briefly describe:	
Impact on other services (e.g. children's / adult social care)	None
What is the potential impact on the financial sustainability of other providers and the wider health and social care system?	None
6 What are the planed timetables & timescales and how far has the proposal progressed?	**Briefly describe:**
What is the planned timetable for the decision making	The improvements that will be secured by the changes are considered urgent by the Trust and its commissioners. These proposals have been considered and supported by the south east London CCG commissioners pending Overview and Scrutiny Engagement. Implementation for Orthopaedics and Gynaecology would be late July and Cataracts would be in November 2014.
What stage is the proposal at?	1. Elective inpatient orthopaedics: Currently running some elective inpatient adult orthopaedic services at Orpington Hospital 2. Elective inpatient gynaecology: Currently running a pilot 3. Non-complex cataract: Planning stages
What is the planned timescale for the change(s)	1. The Trust is proposing to move the remaining elective inpatient orthopaedic operating from Denmark Hill and PRUH to Orpington in July 2014. 2. The Trust is proposing to move inpatient elective gynaecology services in July 2014. 3. The Trust is proposing to move the non-complex cataract activity from Denmark Hill to QMH in November 2014
7 Substantial variation/development	**Briefly explain**
Do you consider the change a substantial variation / development?	**General** We do not consider this to be a substantial variation. The service of three specialties being moved will be improved, specifically around reduction in waiting times and non-cancellation of procedures. In addition, these three service moves will help address emergency and RTT performance at both Denmark Hill & PRUH. The Trust will be encouraging all non-complex cataract patients,

	elective inpatient gynaecology patients and elective orthopaedic patients to have their surgery undertaken at our preferred sites, and we will be working with patients to ensure any anxieties are addressed. However, where a patient chooses to remain at their initial site, arrangements will be made for them to receive their surgery at Denmark Hill / PRUH. In addition the majority of care (outpatients, pre and post-surgery) will remain on current sites. Transport will be provided free of charge to all Lambeth, Southwark and Lewisham patients to ensure the change in location of the service does not impact financially on the patient.
Have you contacted any other local authority OSCs about this proposal?	Yes, all boroughs covered by King's College Hospital: • Southwark • Lambeth • Lewisham • Bromley • Bexley • Greenwich

Agenda Item 7

Report Title: Lambeth, Southwark & Lewisham Sexual Health Strategy and Consultation

Author: Elizabeth Clowes

Position: Assistant Director, Commissioning, LB Lambeth

Contact details: EClowes@lambeth.gov.uk

Purpose of report: To inform Southwark Health and Social Care Scrutiny Committee of the contents of, and consultation period for, the LSL Sexual Health Strategy 2014-2017

Recommendations: The Committee is asked to endorse the strategic principles outlined in the strategy, and comment on any specific issues

1. Background and Service Delivery

1.1 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, sexual health services and protecting the health of the local population.

1.2 These duties were transferred from Primary Care Trusts (PCTs) and included the transfer of 8 NHS staff under Transfer of Undertaking of Protection of Employment (TUPE) who delivered health improvement within the PCTs. The interventions and services commissioned cover all the population for universal access as well as targeted services, and include specialist targeted areas such as teenage pregnancy, sexual health and substance misuse services.

1.3 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). The commissioning service 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 commission open access GUM provision, sexual health prevention and promotion, community contraception, and sexual health in pharmacies and primary care and HIV care and support. The 3-borough team also

commissions termination of pregnancy services on behalf of the Clinical Commissioning Groups.

1.4 Lambeth, Southwark and Lewisham has some of the poorest sexual health in the country. Sexually transmitted infection rates in Southwark high and rising, especially MSM (men who have sex with men) and Black African and young people Southwark has the 3rd highest rate of acute STIs diagnosed in England (2012: 2199.4/100,000). HIV prevalence is also rising – 2012 Southwark rate was 11.7 /1000 15-59 yr olds (England rate 2/ 1000). There is a continuing reduction of under 18 conception, but rates in Southwark still high - 31.8/1000 (London rate 25.9/1000) Termination of pregnancy rates high in Southwark, especially repeat rate (46%) with a concentration in Camberwell and Bermondsey.

2. Strategy

2.1Against 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 ; there was an initial stakeholder engagement day in September 2013, which 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.

2.2 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
- TOPs
- Young peoples services & teenage pregnancy

2.3 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

2.4 The strategy is in consultation until the end of July 2014: it is available on local websites, CCGs have been included in consultation, and specific focus groups have been held in each borough for MSM, black and ethnic minorities and young people, as these three groups were highlighted in the strategy as requiring particular focus. Scrutiny committees in each borough are also being consulted, prior to presenting findings at each health and Well Being Board in October.

2.5 An action plan has been developed to deliver the strategy, which will be overseen by the three boroughs Commissioning Board.

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 Lewisham, 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.

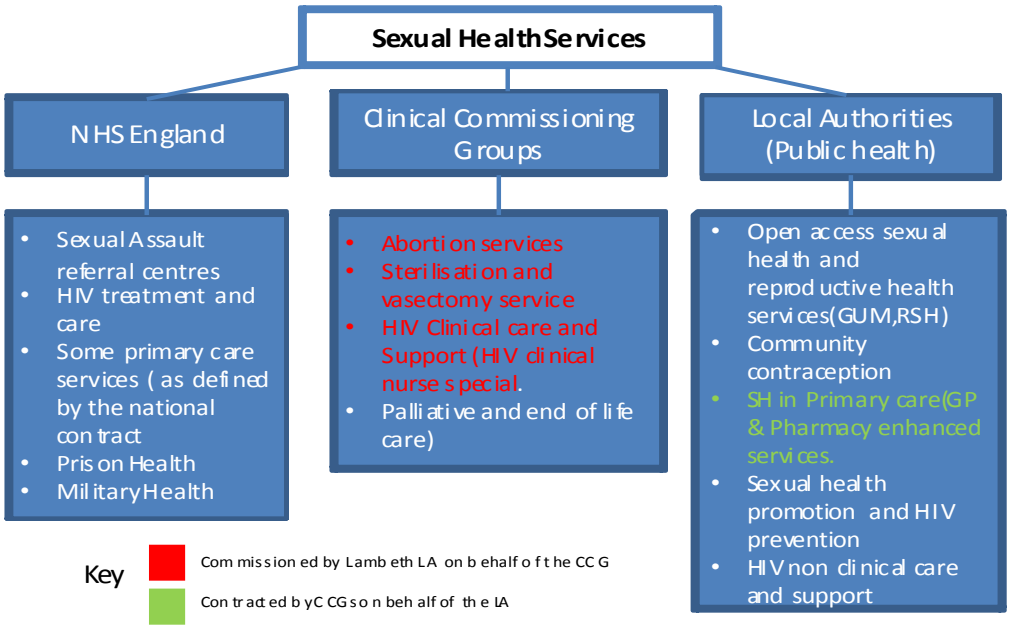
1. Introduction

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 shown below in Figure 1.

Figure 1: Sexual Health Services Commissioning Responsibility



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 collaboratorative 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); 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

1.7 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[1].

Young people under the age of 25 years experience the highest STI rates, making up 64% of Chlamydia and 54% of genital warts diagnoses in heterosexuals[2]. 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[3]. 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).

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.

[1] HIV in the United Kingdom: 2013 report Public Health England :November 2013

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

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

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 2,615 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

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	2400 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 to 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

Source: 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 comprises 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 unwanted 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[4]	500		565
Refugees & asylum seekers			
Service users with learning difficulties (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 17th with 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

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

services are doing well in supporting equitable access as reflected in the diversity of sexual health service users. Table 5 details user profile.

Table 6: Sexual health service user profile

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 15-24 years in 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 2012	Southwark 2012	Lewisham 2012
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 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[5] compared to 50% (95% CI 49-51) in England. This compares to 45% (95% CI 41-50) in Southwark and52% (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 2,615 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.

[5] i.e. with a CD4 count <350 cells/mm3 within 3 months of diagnosis

For Lambeth, the under 18 conception rate (15-17 years old) has reduced by 65.4% (from its highest in 2003) 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 ends in abortion.

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 ends 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

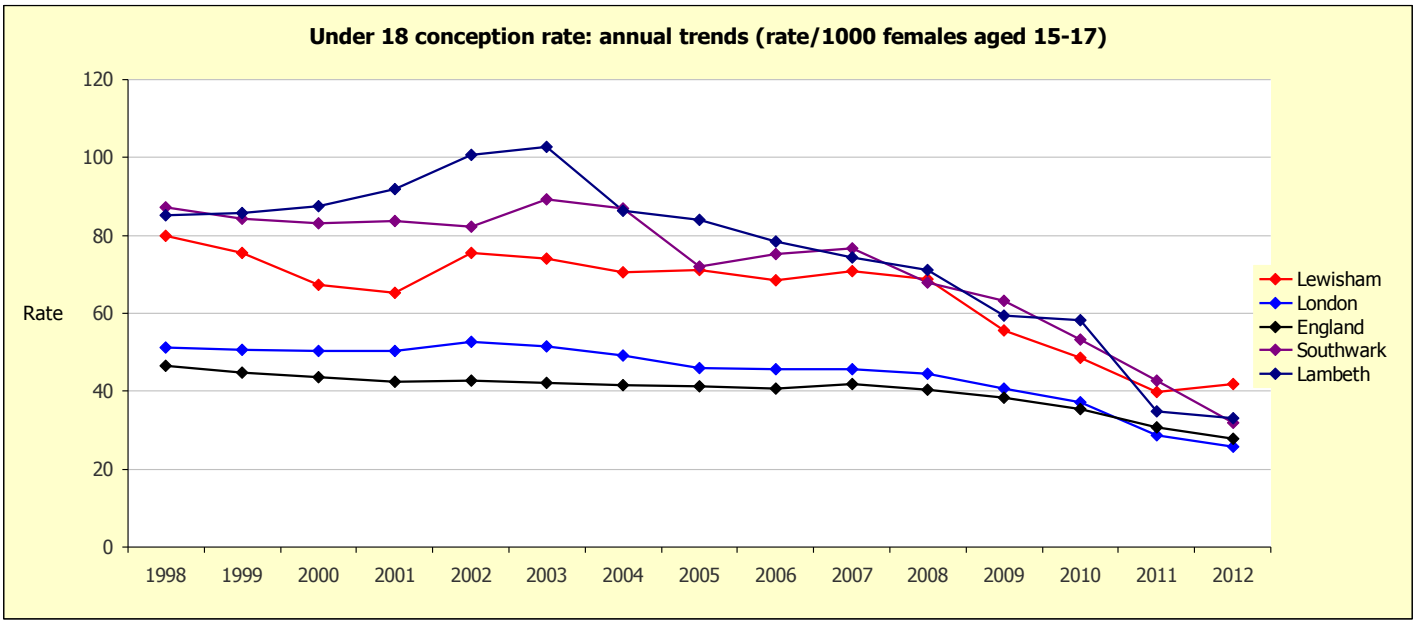


Table 9: Teenage Pregnancy rates 2012

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 Conception per 1,000 in girls	25.9	**33.2**	**31.8**	42.0

aged (2012)				
% of under 18 yr conceptions ended in abortion	62.2%	64.8%	63.4%	61.4%

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		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 acceptiblity 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
- Black Ethnic populations
- People with learning difficulties

- 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 African Communities • 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[6]. The LSL Sexual Health Board will also consider setting targets for switching funding into preventative services.

3.3 Respective budget allocations 2012/13

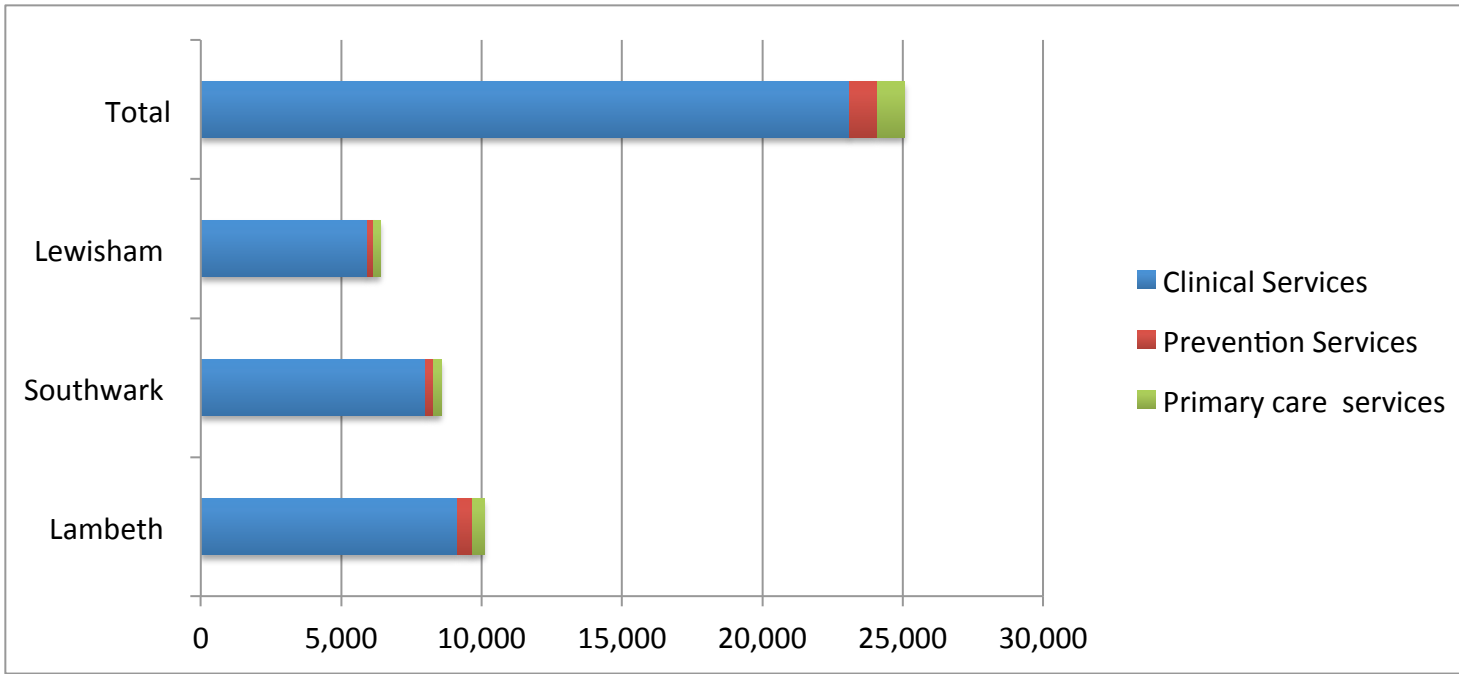
Appendix 2 shows the respective 2012/13 sexual health budgets for the LSL boroughs and highlights a variance in investment across boroughs and across prevention and treatment/care.

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 £9,152,086 compared to Southwark's at £8,010,817 and Lewisham's at £5,930,825.

There is a difference in the investment levels for the three boroughs between prevention (total for LSL is £993,320) and clinical services (total for LSL is £23,093,728). 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 significantly more on prevention (£513,505) than Southwark (£267,719) and Lewisham (£212,096). 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:

Figure 3: Relative spend in £million on clinical, prevention and primary care services in LSL 2013-13

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



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) and prompt access to emergency contraception LARC methods (e.g. intrauterine devices, injectable contraceptives and implants) 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[7]

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 (14 per 1,000 adults aged 15-54). Southwark has the second highest prevalence (11.2 per 1,000) and Lewisham has a lower prevalence (7 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[8] and endorsed by the National Institute of Clinical Excellence (NICE) in 2011[9]. This guidance recommends that expanded HIV testing be conducted in

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

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

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

areas of high HIV prevalence defined as >=2/1000 persons aged 15-59[10]. 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.

[10] 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'. 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. 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. 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.

Lewisham community sexual health service is now part of the new Lewisham & Greenwich Trust, created in October 2013, which also includes the GUM service at Queen Elizabeth Hospital in Woolwich.

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) and Lewisham and Greenwich NHS Trust at the Waldron Health Centre. 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 is the absence of GUM services in Lewisham. (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 "check yourself" 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 GUM 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 Table 8, 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 11 below

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 (Caldecot 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 ongoing 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 broaden the 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 A 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 C Card 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 Appendix 6.

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 commissioning plan, which will include measurable outcomes developed from our aims, 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 post graduate 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 2012/13

Budgets for sexual health services commissioned by Local Authorities				
Sexual health service areas	**Lambeth**	**Southwark**	**Lewisham**	**Total**
Clinical services				
GUM	£5,777,297.00	£5,148,722.00	£1,976 000.00	
RSH/Integrated SHS	£2,830,342.00	£ 2,487,051.00	£3,611,745.00	
Brook	£ 235,341.00	£ 272,716.00	-	
WUSH	£ 261,635.00	£ 78,000.00	-	
SE London Sexual Health Network	£ 15,000.00	£ 12,328.00	£ 10,700.00	
Chlamydia screening online testing	£ 7,000.00	£ 4000.00	£ 13,380.00	
Guy's & St Thomas's;King's College Chlamydia Lab costs	£ 25,471.00	-	£ 319 000.00	
TDL	-	£ 8,000.00	-	
Total	**£9,152,086.00**	**£8,010,817.00**	**£5,930,825.00**	**£23,093,728.00**
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	£ 162,142.00	-	-	
Freedoms condom scheme (C-Card and community				Capped at £95,000.00
GP pregnancy test and Condom scheme				Capped at £63,000 across LSL
Brook C card scheme(Lambeth) / C card (Lewisham) / Condom scheme(Southwark)	£ 56,304.00		£ 10,000.00	
Brook Sexual Health service	£264,921.00	£ 276,419.00	-	
Pharmacy condom scheme	£ 2000.00	-	-	
Total	**£ 513,505.00**	**£267,719.00**	**£212,096.00**	**£993,320.00**
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	£ 82,300.00	£ 119,956.00	£170,157.30	

Chlamydia treatment				
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**	**£259,157.30**	**£968,477.00**
Overall budget	**£10,087,856.00**	**£8,565,591.00**	**£ 6,402,078.00**	**£25,055,525.00**

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				
Targeted & specialist services							
Young people	X??	Brook / Well Centre				X (STIs)	

MSM		Pan London				X	
Prison							
IVD users						pilot	
Violence		Haven / Brook/ GAIA		X			X
Sex workers		Streatham agencies					
Asylum seekers/refugees						X (3 borough)	
Homeless						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.

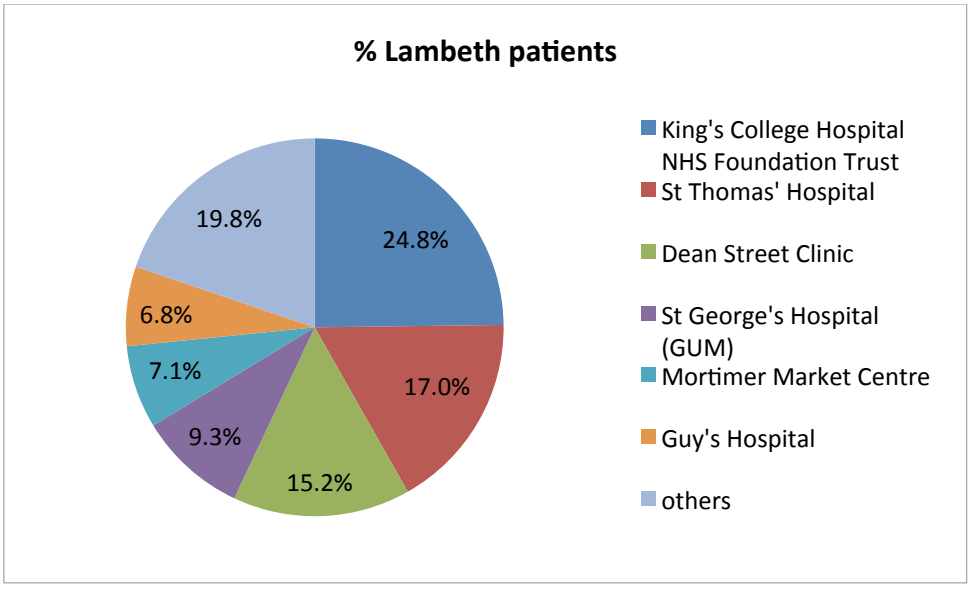
Appendix 4: GUM Service use in LSL 2008 and 20012

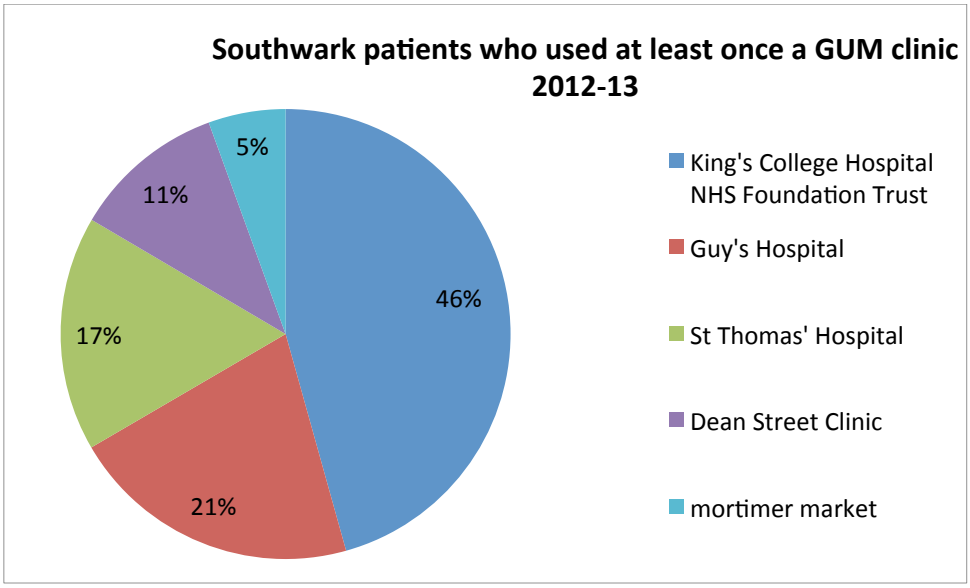
The information below is based on data contained in GUMCAD2 , the Genitourinary Medicine Clinic Activity Dataset version 2 . It is an anonymised patient-level electronic dataset collecting information on diagnoses made and services provided by GUM clinics and other non-GUM commissioned sexual health 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.

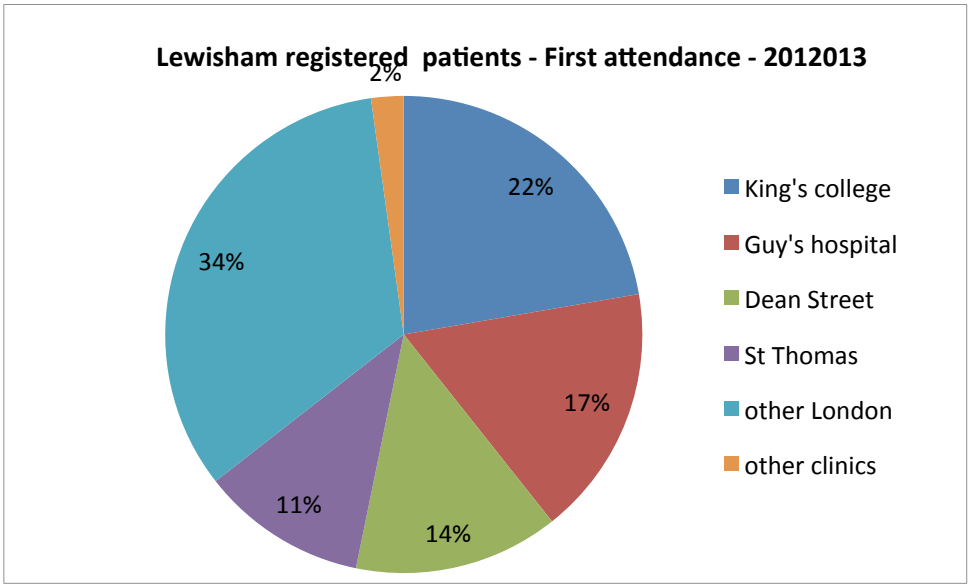
Volume of service 2012-13

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 ongoing 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 toBME 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.

Agenda Item 8

Healthy Communities Committee

Public Health Commission(to be held as standalone inquiry)

Southwark Council took responsibility for public health in April 2013. Since its inclusion, there has been no comprehensive scrutiny of the work that it has done to date, its future priorities, and where the council needs to be doing more to ensure its success.

The inquiry should look into:

- How the Public Health function been integrated into the Council
- What are the national expectations for public health
- What their priorities were over the past 12 months
- What outcomes they can show
- What their priorities are over the coming 12 months

Potential witnesses

- Public Health England
- Public Health Department, Southwark
- Health & Wellbeing Board
- Clinical Commissioning Group
- Cabinet Member for Public Health

Methodology

- Verbal and written submissions from each of the calls for evidence
- 'Scrutiny in a Day'

NB. This would be a standalone inquiry, held separately from the current scheduled Health Scrutiny meetings.

Inquiry One: Healthy Communities

The health of our community is intrinsically important to the health of our borough - the way our constituents interact with their surroundings has a major impact on the health & well-being of our residents.

Many of Southwark's high streets are dominated by shops that encourage poor health and finance choices, which damage the lives of residents and cost the taxpayer money.

With public health now the responsibility of the Local Authority, we should be able to do a lot more to encourage our residents to make positive choices.

This inquiry would look at:

- The current state of our community - from shops, to pubs and bars, to leisure centres
- The current legislation that governs our control over our high streets
- How other councils have taken steps to tackle problems on their high streets
- What we can do as a council to encourage our high streets to be healthier
- What impact this is having on the health of residents

Potential witnesses

- Cabinet Member for Public Health
- Cabinet Member for Community Safety
- Cabinet member for Regeneration
- Chair of Licensing Committee/Head of Licensing
- Chair of Planning Committee/Head of Planning
- Youth Community Council – they conducted a report into the shops on the Walworth Road
- Community groups – e.g. Walworth Society
- Business networks – local & national
    - Tower Bridge RoadAlliance
    - Blue Bermondsey Business Association
    - PeckhamTown Team
    - Walworth SE17 (Walworth Road&East Street Market)
    - Camberwell Business Association
    - Southwark Chamber of Commerce
    - Business Extra

  - British Property Federation
- Business Improvement Districts
  - Better Bankside
  - LondonBridge BID
  - Waterloo Quarter
- Kings Health Partners, Guys & St Thomas
- Public Health Department, Southwark Council
- CCG
- Public Health England
- Healthwatch
- LondonSchool of Economics. LSE Cities Future of London's Town Centres - including the ethnographic studies done on the economies & culture of Walworth Road and Rye Lane
- New Economics Foundation , Reimagining the High Street
- Move Your Money – initiatives with councils in Lambeth, Liverpool & Preston (http://moveyourmoney.org.uk/news/city-of-preston-supports-move-your-money/)
- Citizen Advice Bureaux
- The Portas Review, and update https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6292/2081646.pdf

Methodology

- Visits to high streets throughout the Borough
- Calls for evidence & appearances at committee
- Series of community events - Elephant & Castle; Rotherhithe; The Blue; East Dulwich
- Survey with Southwark residents

Inquiry Two: Home Care

In November 2013 the Council signed up to the Ethical Home Care Charter, which committed to improving working terms and conditions for hundreds of local care workers.

Whilst we have so far committed to a number of these proposals, there are three elements that are as yet not being taken forward.

1. Not using zero hours contracts in place of defined contracts
2. payment for travel time between clients
3. occupational sickness schemes

Through introducing these elements of the EHCC, there will be a significant impact on the working conditions for home care workers.

Through this inquiry, we would hope to further understand where we are up to on delivering each of these elements, and how we can make progress towards achieving them.

Potential witnesses

- Cabinet Member for Adult Social Care
- Adult Social Care team at the Council
- Unison
- Local care organisations

Methodology

- Verbal and written evidence
- Community visits - day with a care worker

Agenda Item 9

General terms of reference for scrutiny committees/sub-committees

Within their agreed policy scope, all scrutiny committees/sub-committees will:

a) produce a one year rolling work programme, which will be approved by the overview and scrutiny committee

b) review and scrutinise decisions made or actions taken in connection with the discharge of any of the council's functions

c) review and scrutinise the decisions made by and performance of the cabinet and council officers both in relation to individual decisions and over time in areas covered by its terms of reference

d) review and scrutinise the performance of the council in relation to its policy objectives, performance targets and/or particular service areas

e) question members of the cabinet and officers about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects and about their views on issues and proposals affecting the area

f) assist council assembly and the cabinet in the development of its budget and policy framework by in-depth analysis of policy issues

g) make reports and recommendations to the cabinet and or council assembly arising from the outcome of the scrutiny process

h) consider any matter affecting the area or its inhabitants

i) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working

j) review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the scrutiny committee and local people about their activities and performance

k) conduct research and consultation on the analysis of policy issues and possible options

l) question and gather evidence from any other person (with their consent)

m) consider and implement mechanisms to encourage and enhance community participation in the scrutiny process and in the development of policy options

n) conclude inquiries promptly and normally within six months

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2014-15

AGENDA DISTRIBUTION LIST (OPEN)

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Dated: June 2014	