POLICY & RESOURCES COMMITTEE	Agenda Item 158 Brighton & Hove City Council

Subject:	**Sexual Health Services**	
Date of Meeting:	**20 March 2014**	
Report of:	**Director of Public Health**	
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Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In April 2013 the responsibility for commissioning sexual health services transferred from the NHS to local authorities.

1.2 Commissioning of these services for Brighton and Hove beyond March 2015 will require a new contract.

1.3 This paper makes recommendations on the process for awarding the contract.

2. RECOMMENDATIONS:

2.1 That the Committee agrees for the commissioners to seek to negotiate a contract to deliver an integrated sexual health service with the current providers; with the option of moving to a competitive process if negotiations fail;

2.2 That the Director of Public Health be granted delegated authority to conduct the negotiations on the Council's behalf, and to run a competitive procurement in the event that the negotiations fail.

2.3 That the Committee receives a report on the outcome of the negotiations before a new contract is awarded

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The main clinical sexual health services in Brighton and Hove are the Claude Nicol genitourinary medicine (GUM) clinic at the Royal Sussex County Hospital and the Morley Street community contraception and sexual health (CASH) service. These services are provided by the Brighton and Sussex University Hospitals Trust (BSUH) and the Sussex Community Trust (SCT) respectively.

3.2 There is a degree of overlap between the services to support patients to access contraception and sexually transmitted infection testing and treatment services appropriately, regardless of the setting.

3.3 The current contracts for these services were due to end on the 31st March 2014.

3.4 The Policy and Resources Committee of July 2013 agreed that the contracts should be extended for a period of 12 months to allow a full review and re-design prior to a procurement by competitive tender.

3.5 The preferred service model for the new contract is a fully integrated sexual health service

3.6 The provision of integrated sexual health services is supported by guidance from the relevant professional bodies including the Faculty of Sexual and Reproductive Health (FSRH), British Association of Sexual Health and HIV (BASHH), the British HIV Association (BHIVA), the Medical Foundation for AIDS and Sexual Heath (MEDFASH), the Royal College of Obstetricians and Gynaecologists (RCOG) and NICE, and relevant national policy and guidance issued by the Department of Health and Public Health England.

3.7 In awarding these contracts, the Council is obliged to follow a process that is fair, transparent and non-discriminatory; and which delivers value for money. There is uncertainty in legal terms about the scope of this requirement, and in particular about the extent to which a contract for services of this nature must be advertised before the contract is awarded. Detailed legal advice is set out in the annex to this report, which will need to be considered in the closed part of the meeting. Members will need to take this advice into account before coming to a final decision as to how to proceed.

3.8 In order to comply with the transparency obligations, it is proposed that the Council publishes a notice of how it intends to proceed, once the committee has come to a decision.

3.9 There are a number of practical reasons for the recommendation to limit negotiations to the current providers in the first instance. These are as follows:

3.10 An open competitive process will not deliver any improvements on quality or price that could not be achieved through negotiation with current providers.

3.11 A validated, robust and transparent pricing system that is fair to both commissioners and providers is available

3.12 An integrated sexual health tariff has been developed in conjunction with the London Sexual Health Programme. This tariff covers over 140 care pathways using the latest best practice and clinical standards required to deliver better health outcomes. Each component of care has been priced based on what it costs to deliver.

3.13 The tariff has demonstrated to be cost saving compared to expenditure under the non-mandatory GUM payment by results tariff and block contracts

3.14 There is a significant degree of overlap between the sexual health services and other related services provided by BSUH (e.g. HIV treatment and care) and SCT (e.g. the chlamydia and gonorrhoea screening programme)

3.15 A recently published paper by The Royal College of Physicians and BASHH highlights some potentially negative impacts of competitive tendering and argues for a negotiated programme of continuous service improvement instead.

4 ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The alternative option to the recommendations would be to move straight to a competitive tender from the open market.

5 COMMUNITY ENGAGEMENT & CONSULTATION

5.1 A patient, public and stakeholder consultation on the future of sexual health services was undertaken during January and February 2014.

5.2 The consultation addressed the characteristics of sexual health services that are important to residents to inform service planning.

5.3 The consultation was via the Brighton & Hove City Council consultation portal and through a paper questionnaire distributed from a variety of services across the City.

5.4 The consultation was also promoted widely through the local media and relevant websites.

5.5 Preliminary results show that a significant majority of respondents to the online survey would prefer an integrated sexual health service

6. CONCLUSION

6.1 The negotiation of a new contract for sexual health services with the current service providers would be more efficient and cost effective than undertaking a competitive tender process

6.2 A competitive tender would not necessarily lead to any improvements in quality or price that could not potentially be achieved by negotiation

6.3 A competitive tender process is not ruled out should it not be possible to negotiate a contract

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 The current contracts in place for clinical sexual health services of approximately £4m are funded through the ring fenced public health grant (£18.1 million for 2013-14, rising to £18.6m in 2014-15). Results of the contract negotiations will be reported back to Committee before any new contract is awarded for the period from 1 April 2015. Any resulting cost savings will be reflected in the development of the budget strategy for 2015/16 and monitored through the budget monitoring process.

Finance Officer Consulted: Anne Silley *Date: 11/03/04*

Legal Implications:

7.2 The legal implications associated with the report are set out in appendix 1 which is exempt from disclosure to the press and public and will be considered in Part 2 of the meeting.

Lawyer Consulted: *Jill Whittaker* *Date: 14/02/2014*

Equalities Implications:

7.3 Equalities questions have been addressed as part of the public and patient consultation on the future of sexual health services. A full equalities impact assessment will be undertaken prior to the award of any new contract.

Sustainability Implications:

7.4 There are no sustainability implications arising from the report.

Any Other Significant Implications:

7.5 None.

SUPPORTING DOCUMENTATION

Appendices:

1. Legal Implications – Exempt Category 5 (circulated to Members only).

Documents in Members' Rooms

None

Background Documents

1. BASHH and RCP paper on key threats from tendering of sexual health services, November 2013.