Agenda Item No: 5

Recommissioning Sexual and Reproductive Health Services

To:	Adults and Health Committee
Meeting Date:	27 June 2024
From:	Executive Director of Adults, Health, and Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2024/005

Executive Summary: This report describes the issues that impact upon the re-commissioning of the Integrated Sexual and Reproductive Health Prevention and Treatment Service. The Committee is asked to consider the description of the current services, the epidemiology, needs assessment information along with Service scope and procurement options for commissioning the services.

Recommendation: Adults and Health Committee is being asked to agree the following recommendations:

a) To re-commission the Integrated Sexual and Reproductive Health Treatment Services as a shared service across Cambridgeshire County Council and Peterborough City Council.

b) That Peterborough City Council delegates to Cambridgeshire County Council the authority, through a Delegation and Partnership agreement, to enter into a Section 75 agreement on its behalf with the current provider Cambridgeshire Community Services to deliver the Integrated Sexual and Reproductive Treatment Service across Peterborough.

c) That the Section 75 agreement for the Integrated Sexual and Reproductive Treatment Service with Cambridgeshire Community Services includes the provision of the Prevention of Sexual Ill Health Service for Cambridgeshire County Council **only.** The Prevention Service will only be provided for Cambridgeshire County Council residents.

d) The Section 75 with Cambridgeshire Community Services has a total value of £36,112,278 over 6 years with break options at years four and five. The total value is comprised of the following different funding streams.

Cambridgeshire County Council:
Sexual and Reproductive Health Treatment Service: £22,851,528
Prevention of Sexual Ill Health Service: £1,988,160

Peterborough City Council:
Sexual and Reproductive Health Treatment Service: £11,272,590

e) Delegate responsibility for awarding and executing a Section 75 agreement for the provision of Integrated Sexual and Reproductive Health Prevention and Treatment services starting April 1, 2025, until March 31, 2031, with break options at four and five years to the Executive Director for Adults, Health, and Commissioning in consultation with the Chair and Vice Chair of the Adults and Health Committee.

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1. Creating a greener, fairer, and more caring Cambridgeshire

1.1 The Prevention of Sexual Ill Health Prevention Service will support delivery of Council's Strategic ambitions as detailed below.

1.2 *Ambition 1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.*

Ambition 2: Travel across the county is safer and more environmentally sustainable.

A proportion of the services and meetings are provided virtually which means there is less travel across the area, affecting carbon emissions.

Providers are asked to adopt sustainable travel options whenever possible. If the recommendation for the contract award is approved the current provider as an NHS organisation and therefore is subject to obligations relating to its net zero omissions strategy. The provider also has its own "Green Plan" which has range of initiatives that will support ambitions one and two.

Ambition 3 Health inequalities are reduced.

The commissioned service is universal, but it is targeted at certain high-risk groups which includes young people, the homeless, drug and alcohol service users, men who have sex with men, people with learning disabilities who often experience health inequalities and have overall poorer health outcomes.

Ambition 4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

The Service aims to reduce the risk of transmission of sexually transmitted infections through population level and targeted prevention interventions. This includes the provision of prompt effective treatment and interventions to reduce the risk of unplanned pregnancies. The services also work with other services to address the often-wide ranging needs of high-risk groups.

Ambition 5: People are helped out of poverty and income inequality.

The Services aim to ensure the best possible health outcomes for the population and service users. For example, providing treatment for HIV enables people to live and work and supporting people to avoid unplanned pregnancies.

Ambition 6: Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

The Services enable people to remain in good health. They also work to decrease the stigma associated with poor sexual health which includes living with HIV.

Ambition 7 Children and young people have opportunities to thrive.

The Service is accessed by high number of sixteen- to eighteen-year-olds. It is aware of the particular needs of young people and shapes services to address these needs.

2. Background

Sexual and Reproductive Health (SRH) Services Scope

2.1 The provision of sexual health services is a mandatory Public Health function for local authorities. Robust sexual health services enable sexually transmitted infections to be treated promptly to reduce the risk of their spread. Historically sexual health or Genito Urinary Medicine (GUM) services were provided in acute hospital settings but in recent years they have become community services and integrated with contraception services. In Cambridgeshire, the model is known as community Integrated Contraception and Sexual Health (iCaSH) services.

It is mandatory that Sexual Health Services provide open access and they do not require a referral. People can access the services anywhere. Local authorities are obliged to pay "out of area" providers who have treated any of their residents.

2.2 Currently Cambridgeshire County Council (CCC) has a Section 75 with Cambridgeshire Community Services (CCS) for the provision of Sexual and Reproductive Health (SRH) services, known as iCaSH, across Cambridgeshire and Peterborough. This shared service was established though Peterborough City Council (PCC) delegating authority, through a Partnering and Delegation agreement to CCC to enter into the Section 75 on its behalf.

2.3 The current Section 75 was established to cover 2021-22 and was extended until March 2025. A competitive procurement had been planned for 2020 with a new contract effective from April 2021 but due to the pressures created by the COVID-19 pandemic the then Health Committee agreed the initial Section 75 and its extension to March 31, 2025.

2.4 The service model for re-commissioning had been evolving into a more integrated service following several national reports. The Health and Social Care Act 2013 divided the commissioning responsibilities for SRH services between Local Authorities, Clinical Commissioning Groups (CCGs), and NHS England (NHSE). In 2017 Public Health England (PHE) and the Department of Health and Social Care (DHSC) surveyed commissioners of sexual health services across the country to gather feedback on their commissioning experiences. The survey reported fragmentation of commissioning that was associated with the spread of commissioning responsibilities across three main commissioning bodies (Local Authorities, NHSE, and CCGs) because of the commissioning arrangements created through the 2013 Health and Social Care Act.

PHE invited CCC and other local commissioners of SRH services across Cambridgeshire and Peterborough to explore opportunities for alignment and collaborative commissioning of SRH services. Consequently prior to 2020/21 a considerable amount of work, led by CCC commissioners, was undertaken to develop a collaborative model that would better meet the often-multiple complexes needs of iCaSH service users.

The pandemic necessitated a more pragmatic approach, and Section 75 was more limited in scope than had been planned. Currently it includes sexual health treatment and contraception services along with HIV services. HIV commissioning is the responsibility of NHSE, and it is a partner to Section 75. The current Section 75 did, however, include a Single Point of Access which is well supported by service users. Developing a more integrated model will be an objective for the new service.

2.5 The prevention of sexual ill health is an essential element in maintaining and improving the sexual and reproductive health of the population. Currently we commission the Terence Higgins Trust (THT) to provide the Prevention of Sexual Ill Health Service. This is a shared service working across the CCC and PCC areas. PCC has delegated the authority to CCC, through a Delegation and Partnering agreement, to commission the service on its behalf. The Service was commissioned through a competitive tendering process and the contract ends on the 31 March 2025.

The Prevention Service works at a population level for all ages to promote sexual and reproductive prevention messages. It works in a range of settings and runs campaigns and other promotional activities. As well as having a prevention focus for the whole population it plays a key role in working with high risk and often under-served population groups such as the gypsy traveller communities, the homeless, men who have sex with men. It provides support to those living with HIV around their mental and physical health, socio-economic issues and coping with stigma. The service also works with young people in schools and other social settings along with running the condom distribution and chlamydia screening services for young people.

Trends in Sexual and Reproductive Health in Cambridgeshire and Peterborough

2.6 National increases in sexually transmitted infections.

Recent national reports have described large increases in the rates of Sexually Transmitted Infections (STIs). The Local Government Association (LGA) report published in January 2024 reported the following

- That over two-thirds of local authority areas had seen increases in rates of gonorrhoea and syphilis since 2017.
- Almost all (97 per cent) council areas have seen an increase in the diagnoses rate of gonorrhoea, with 10 local authorities seeing rates triple.
- 71 per cent of areas have seen increases in cases of syphilis.
- More than a third (36 per cent) of local authority areas have also seen increases in the detection of chlamydia.
- Demand for sexual health services has continued to grow, with nearly 4.5 million consultations carried out in 2022, up by a third since 2013. In 2022 there were 2.2 million diagnostic tests carried out, a 13 per cent increase from the year before.

- Although some of the rise has been attributed to increased diagnostic testing, and the ongoing work of councils to improve access to services to make it easier for people to get tested regularly, the scale suggests a higher number of infections in the community.

Local trends: Cambridgeshire and Peterborough Sexual Reproductive Health Needs Assessment

2.7 This needs assessment was completed in February 2024 with the objective of informing any new SRH commission. The needs assessment identified the recent trends across both areas that reflect the national picture found in the LGA report.

- New STI diagnosis rate per 100,000 was highest in Cambridge followed by Peterborough. The rate in Cambridge City was higher than the England average. All other areas are below the England average although Peterborough is above the regional average. East Cambridgeshire and Fenland have the lowest rates in Cambridgeshire and Peterborough at less than half the rate of the England average.
- Overall STI rates declined during the COVID-19 pandemic. However, in some areas such as Cambridge City and Huntingdonshire these rates started to increase in 2022 although not yet to the levels in 2019.
- The national increase in gonorrhoea rates in 2022 meant they were higher than in 2019. There was a similar overall pattern in Cambridgeshire and Peterborough but with variations between the districts. Diagnosis rates were highest in Cambridge City and Peterborough and were similar to the England figure, but five times higher than East Cambridgeshire, which has the lowest rate.
- Similarly, there has been national upward trend in syphilis diagnosis between 2008 and 2019 although this has slowed in recent years. In Cambridgeshire and Peterborough diagnosis rates have increased driven by rates in Cambridge City and Peterborough but currently remain similar to the England figure.
- The new diagnosis HIV rate was significantly higher in 2022 in Cambridge and Peterborough than the England average. Testing is an important part of addressing HIV and the testing rate has been falling across all areas. It is significantly lower in all districts compared to the national rate with the exception of Peterborough.
- There has been concern in recent years about late HIV diagnosis in Cambridgeshire and Peterborough. Late HIV diagnosis increases the risk of HIV-related morbidity and mortality for individuals. It may also increase the chance that they have unknowingly passed HIV on to contacts.
- Nationally teenage conception rates more than halved between 2011 and 2021. The England under 18s conception rate per 1,000 females aged 15-17 is 13.1%. Cambridge, Fenland and Huntingdonshire have rates that are similar to the England average. East Cambridgeshire and South Cambridgeshire have an under 18s conception rate significantly below the England average. Peterborough has a higher rate than the England or regional average however it still represents a lower rate than seen in Peterborough 10 years ago.

In summary there is an overall increasing upward trend in STI rates with the diagnosis rate for most STIs highest in the two cities (Cambridge and Peterborough). Both areas have younger populations, and it is known that young people experience the highest diagnosis rates of the most common STIs, this may be due to higher rates of partner change among

those aged 16 to 24 years. These higher values may also reflect a greater access to testing services, and this has identified unmet need.

There are now national action plans to address these upward trends. The national HIV Action Plan (15), published in 2021 by the Department of Health and Social Care (DHSC), commits to ending HIV transmissions in England by 2030, and has an interim target of reducing HIV transmissions by 80% between 2019 and 2025.

Increase in service activity

2.8 There has been an increase in demand for treatment services and this needs to be seen in the context of the epidemiology described above. Clinic activity is divided into face-to-face consultations, virtual services, and telephone contacts. Face to Face consultations have returned to pre-pandemic levels along with an increase in numbers accessing tests online, which also increases demand for treatment appointments. Consultation with service users and the public as part of the needs assessment found that a large proportion of people preferred face to face appointments, but many would access virtual services.
An additional factor is the growth in the 16–25-year-population group, who are the highest users of the Service and favour virtual options.

Table 1 shows an increase in activity of over 18% in the iCaSH service from 2019 to 2022/23. The pressures are attributed to virtual services, dating apps and geosocial networks along with the increase in the 15–24-year-old population is contributing to these pressures. (The overall fall in activity for 2020/21 reflects the impact of the COVID-19 pandemic)

Table 1: Activity increases.

Local authority	Total activity 19/20	Total activity 20/21	Total activity 21/22	Total activity 22/23
Cambridgeshire Total	34,398	29,294	48,243	45,816
Peterborough Total	23,658	24,559	22,455	25,288
Total	**58,056**	**53,853**	**70,698**	**71,104**

Prevention of Sexual Ill Health Services

2.9 The epidemiology reinforces the need for a Prevention of Sexual Ill Health Service. However, the information that emerged from consultation with service users, residents, clinicians, and other professionals presented other challenges for the Prevention service. Concerns focused very much upon the needs of high-risk groups that related to lack of information in accessible formats with specific concerns for LGBTQ+ and men who have sex with men (MSM), people with physical and learning disabilities, ethnic minorities where language barriers, homeless people, substance misuse including sexualised drug use, prisoners on release and sex workers.

The needs assessment consulted widely around the needs of young people and made the following recommendations.

- Review of current offer to schools across all system partners including health, education, and public health to ensure opportunities are maximised to promote healthy behaviours in relation to sexual and reproductive health.
- Provide clear targets and outcomes for delivery of school prevention programmes.

The evidence for working with young people to decrease their risk-taking behaviour. supports a holistic approach which provides better outcomes, rather than focusing upon a specific behaviour.

This thinking has been further developed and has been incorporated into the paper for Commissioning a new Children and Young People's (CYP) Prevention service that will incorporate the currently commissioned Healthy Schools Service.

It is proposed that the new CYP prevention service will work with children and young people in schools and other appropriate settings including groups that have higher levels of need such as young people with learning disabilities. This approach will also complement the development of integrated place-based models for the delivery of children and young people's services. This is being taken forward through the Children and Young People's Committee.

2.10 The implication for the current model for prevention services is that it should focus upon the needs identified nationally and locally for the adult population and especially for high-risk groups.

The following deliverables will need to be strengthened and developed.

- General and targeted information to improve knowledge and awareness of sexual health and contraception issues through promotional activities and campaigns using appropriate media for the target population groups, which includes all age groups.
- Alongside universal information activities the Service will target vulnerable people and high-risk groups to increase awareness and knowledge about late testing for HIV.
- Befriending activities to engage vulnerable and high-risk groups living with HIV supporting them to access health and other support services to ensure that their complex needs are met to prevent further adverse health outcomes.
- Develop referral pathways between different support organisations providing support to clients with complex needs.
- Build capacity and skills for improving sexual health by working with partner organisations, communities, and target groups.

These developments will require an integrated approach across different organisations including the community SRH treatment services. The SRH service treats many people from high-risk groups and has close links with the other services that work with them, including the Prevention Service. It also is the service that is first to identify any STI increases in the population and specific groups.

3. Main Issues

New Service

3.1 Overall the needs assessment findings show that there are some ongoing and new challenges for the services. New diagnoses of sexually transmitted infection rates have returned to pre-pandemic or in some cases such as gonorrhea higher than the 2019 rate. In Peterborough the teenage pregnancy rate, although improved, has stagnated at just above the national rate. SRH services must be able to respond to situations which pose a threat to population health. The Service had to deal with the Monkeypox outbreak, on top of the pandemic, which put a considerable strain on the service. Looking forward as gonorrhea rates increase nationally it has been indicated that the services will be asked to offer vaccination for both monkeypox and gonorrhea. The introduction of HIV “opt out” testing initially at Hinchingbrooke and Peterborough hospitals will mean that HIV testing will be routine. This potentially could increase the demand for HIV services at SRH clinics.

The new integrated SRH treatment service will not significantly change in scope or the model for delivery. However, the consultation and engagement activities with service users and the public, undertaken as part of the needs assessment, identified development areas. These include accessibility, communication and the unmet need of specific groups and areas. Other development drivers are the integration of related services, for example gynaecological and termination services, to enable patients to have their holistic clinical care needs met along with services that will enable wider socio-economic needs to be addressed. The integration of services was started prior to the pandemic prompted by national concerns about fragmented commissioning and will be revisited. Addressing prevention needs is an integral part of these developments and is part of the integration of services so that all opportunities for prevention are utilised.

Integrating Prevention and Treatment

3.2 It is recommended that the Prevention of Sexual Ill Health Service is commissioned as part of an integrated prevention and treatment service. Sections 2.9 and 2.10 describe the prevention needs and areas for development. In summary alongside population level interventions there will need to be a focus on addressing the needs of LGBTQ+ and men who have sex with men (MSM), people with physical and learning disabilities, ethnic minorities where language barriers, homeless people, substance misuse including sexualised drug use, prisoners on release and sex workers.

Currently the Prevention Service works with all ages. However, as described above it is proposed that prevention activities with children and young people should not? be commissioned as part of the new Prevention Service. Consequently, this commission will focus on adult prevention needs.

3.3 These developments will require an integrated approach across different organisations including the treatment services. The current treatment Service treats many people from high-risk groups and has close links with the other services that work with them, including the Prevention Service. The treatment Service is often first to identify any increases in sexually transmitted infections or signals in the population and specific groups and take initial action, working with the Prevention services.

3.4 We were recently contacted by the Chief Executive of the Terence Higgins Trust (THT) which is our provider of the current Prevention service. The organization is withdrawing from being a provider of prevention services, though it will continue with its long-standing advocacy work. This change was forced by the inflationary pressures which has made service delivery too challenging.

Prior to meeting with THT we had discussed its change of direction with Norfolk and Milton Keynes local authorities. Norfolk had already brought the THT Prevention activity into its SRH treatment service which as in Cambridgeshire and Peterborough is provided by CCS. Milton Keynes had planned a similar approach. The rationale was that the market had shrunk with fewer provider options and there was a need to retain a very specialist workforce. There were cost benefits from the approach such as overheads which were absorbed into the bigger services. Although the risks of prevention funding being diverted into treatment services were acknowledged.

3.5 The change in THT circumstances along with the new Children and Young People's Prevention service has led to re-assessment of the original proposal to commission the Prevention Service separately from the Treatment Service. The preferred proposal is to commission an integrated Prevention and Treatment Service for adults. However, an integrated prevention and treatment service will need to be carefully monitored to ensure that prevention services are not compromised when treatment services are experiencing a high level of demand and costs.

Shared Service across Cambridgeshire and Peterborough: Integrated Sexual and Reproductive Treatment Service

3.6 It is recommended that the shared service model across CCC and PCC is continued and that PCC delegates authority to CCC for it to commission the Service on its behalf. There are some key benefits and risks underpinning this recommendation that are considered in the options appraisal found in Table 2.

Benefits and Risks considered in the option appraisal

- What is the benefit to Cambridgeshire County Council of joint commissioning with Peterborough City Council?
- Whether there are any financial risks to the Council, due to any ongoing financial challenges faced by Peterborough City Council, and how do we protect ourselves against the impact of this.
- Maintaining a robust local market capacity to meet the needs of Cambridgeshire residents.
- Ensuring that resources, e.g. procurement, are targeted at delivering Cambridgeshire outcomes. Therefore, it is imperative in the instances where we progress with joint procurement arrangements that there are partnership agreements in place between both parties.

Table 2: Options for commissioning SRH services across Cambridgeshire and Peterborough

Criteria	Shared	CCC only
Meets needs of residents/patients through a more collaborative model of service delivery.	Patient flows: Service users access services across both local authorities.	More difficult to understand demand for services, less easy in some situations to trace contacts quickly, therefore a higher risk of the spread of infections. (see below)
Value for money	In periods of increased demand, a block contract arrangement across the two areas supports easier management of cost pressures through the avoidance of tariffs.	There is national tariff that applies to residents who access services out of their local authority where they reside. In periods of increased demand CCC would have to fund residents receiving care at PCC services at tariff rates, which could create a cost pressure.
Reduces infection risk.	Users access services outside of their local authority area as they often work, socialise, or go to school/college in other areas. This facilitates the spread of infection. It is important to identify infection risks and treat as quickly as possible. A shared service can pick up any trends/risks that are found across both areas along with taking action to reduce spread more widely.	There would be slower identification of trends and risks as these would have to be processed by national agencies which can take several weeks or even months.
Strengthens specialist workforce	SRH services have specialist clinicians. They are in short supply and recruiting is challenging. A shared services means that the more highly skilled staff can work across the whole service according to need.	Potential competition for scarce specialist staff. Unsafe staffing levels.
Shared management costs	Management cost efficiencies at service manager level.	These would not be available in a CCC only model.
All residents/patients receive the same level of quality services	Residents would have the same standard of care wherever they access services across Cambridgeshire and Peterborough. It supports collaborative working to further develop the service with the Integrated Care System/NHS England which commission related services for the whole area e.g. termination services, cervical screening	Risk of lack of consistency of care for residents and inequities.

3.7 The advantages of a shared service are supported by the consultation undertaken as part of the needs assessment with service users, the public, clinicians/managers in current provider and other local services.

Commissioning Approach: Section 75

3.8 A Section 75 is an agreement established under the NHS Bodies and Local Authorities Partnership Arrangements Regulations (2000) and then further developed under the Section 75 NHS Act (2006). It includes enabling local authorities and NHS bodies to enter into arrangements whereby NHS bodies can carry out local authority health related functions together with their NHS functions. They are essentially partnership agreements that will enable an improvement in the functions or services.

It is recommended that a Section 75 is entered into again with Cambridgeshire Community Services for the delivery of the Integrated Sexual and Reproductive Health Treatment Service as a shared service across Cambridgeshire and Peterborough. The rationale provided by the local authority legal and procurement teams is in line with the legislation that where Section 75 partnering arrangements are likely to lead to an improvement in the way in which the function can be exercised, and consultation with interested parties has been fulfilled, then the local authorities may exercise power to enter into section 75 agreements.

3.9 It is also recommended that Section 75 includes the Prevention Service as well as the Treatment service for CCC **only**. PCC is not proposing to recommission a specific SRH prevention service for Peterborough though Section 75. The integration of the Prevention Service into Section 75 would help mitigate THT's main concern about the loss of staff through their concerns about an uncertain future for the service. Staff would be able to TUPE into the new Service.

3.10 There is clear evidence that the current Section 75 with Cambridgeshire Community Services has enabled collaborative working with CCC commissioners and led to the development of the Service and the management of challenges which have arisen in recent years.

The Service is clinical and is governed largely by clinical standards for delivering treatment. This will not change going forward. The findings from the needs assessment identified development requirements for aspects of delivery e.g. website developments but these are building on what is currently delivered. In terms of prevention there is a need to focus on the inequalities experienced by high-risk groups. A new Section 75 will build on the collaborative approach that is well established between CCS and the commissioners.

The advantages and potential risks of a new Section 75 with CCS are described below.

Section 75: Positive service delivery, collaborative working, and service development

3.11 CCS is delivering the current agreement to a high standard. It has increased its activity and is meeting targets for delivery. These positives have been over the course of the contract when it has also managed a considerable increase in activity with numbers post pandemic above those of 2019. (Table 3)

Table 3: Activity increases.

Local authority	Total activity 19/20	Total activity 20/21	Total activity 21/22	Total activity 22/23
Cambridgeshire Total	34,398	29,294	48,243	45,816
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Total	**58,056**	**53,853**	**70,698**	**71,104**

3.12 CCS has had a long experience of working in the area and knows the needs of the wider population and its high-risk groups very well. The Service has demonstrated on many occasions when it will flex to meet the needs of high-risk groups with complex needs and who experience inequalities. The Service links with organisations working with these groups. And there are many examples when clinicians have made exceptional efforts to ensure that high risk patients are diagnosed and treated, for example sex workers or patients not accessing their HIV treatment.

This work has meant that the Service has built up an effective trusted relationship with local providers and organisations which includes Safeguarding services, the police and housing services. These have evolved overtime and enable the service to meet the range of different needs. A new provider would have to develop their own relationships which would take time and would not have an organisational "memory" of addressing local issues and working in close partnership with other bodies. These factors present a risk to these partner agencies as there is always a period of de-stabilisation when there is change of provider which can impact on how other services are provided. For example, the homeless have high risk of sexual poor health but there are long standing links between the services.

During the COVID-19 pandemic and the Monkeypox outbreak the Service responded quickly and flexibly. It took on additional work without any additional funding. This included introducing and developing new technologies for virtual services, on-line testing, and postal contraception. The Service has recovered well from the pandemic and continues to work to improve services. For example, there has been consistent feedback that there is a gap in meeting the psychosexual needs of patients. The Service is currently piloting these services as there is limited information about their impact on outcomes and clinic attendances.

3.13 The Service has quality standards in place that meet the requirements of National Institute for Care Excellence (NICE) and British Association for Sexual Health and HIV (BASHH). The last Care Quality Commission (CQC) assessment was for the Trust took place in 2019 when it was given an outstanding rating. The iCaSH services were praised for an innovative approach in providing accessible information and new approaches to testing and HIV treatment.

The recent Sexual and Reproductive Health needs assessment included surveys and interviews with service users, the public, iCaSH clinicians and other service clinicians along with non-clinical staff. The responses consistently stated a very high satisfaction with the quality of the services provided assessment from service users which and highlighted the following key areas

- Patients were positive about their clinical experiences with iCaSH with nearly all saying that they would be happy to recommend the service to their friends and family.

- Patients praised the care and attention shown by practitioners.
- Good local relationships and commitment to delivery of high-quality services were clear through the engagement and expert panel.
- Feedback on being able to order STI testing kits online was positive, with its speed and ease of use being positive points.

3.14 CCS has built up a very skilled workforce in this specialist field. They have an ongoing staff training programme which has enabled the recruitment and the building of a highly skilled team increasing capacity and quality. Although TUPE would apply a change of provider is associated with service de-stabilisation and staff losses. This is a concern as it is difficult to recruit this specialist workforce and the CCS staff have played a key role in the service developments.

Section 75: Financial benefits

3.15 CCS has over the past ten years worked with the local authority to improve access especially in the rural areas and more deprived areas and has made substantial investment in renovating/building modern clinics. It invested in a new clinic in Wisbech which previously had very limited facilities and did not have a consultant led clinic as specialist clinical equipment is required. This means that patients do not have to travel to Peterborough or Kings Lynn. In Huntingdon, the Service moved from Hinchingbrooke Hospital to the middle of the Oxmoor Estate, one of our more deprived areas. In Cambridge City the Clinic is an area where many high-risk groups are found, and the provider also upgraded the clinic at this site.

The current clinics are sited at Cambridge City, Huntingdon, Ely and Wisbech and Peterborough. All are accessible by car within thirty minutes but take an hour on public transport, which is limited in some areas. In recent years we moved services out of the acute hospitals into these community locations to improve accessibility. Although of course the locations are still challenging for some, but it is not feasible to locate expensive clinics at many locations.
CCS owns the clinic sites and many other across Cambridgeshire and Peterborough and consequently it does not have rental costs. A new provider would be asked to locate services in similar locations but would not have the advantage of lower estate costs.

3.16 Benchmarking current service costs have limitations as areas include different elements in their services. However Public Health colleagues from local authorities in the East of England did share their costs for analysis. In summary Cambridgeshire and Peterborough have the lowest cost per patient accessing the services, partly attributed to high number of patients who access its virtual services.

CCS currently provides the majority of SRH services across the East of England, and this has not encouraged the development of the provider market. However, comparing the quality and value of services against the risks of de-stabilising the delivered services with the need to develop the market supports a Section 75 agreement. Two recent procurements in the area have attracted single bidders who were awarded the contracts, but CCS did not bid for these.

3.17 Inflationary pressures have become increasingly worse over the past eighteen months. The provider has managed these through making efficiencies without any additional funding.

Section 75: Net Zero

3.18 As an NHS organisation it is obliged to adhere to its commitment to net zero and CCS is committed to meeting the ambition. It has its own Green Plan that lays out a number of commitments which highlights some specific areas such as the provision of sexual transmitted testing kits directly to homes (postal), further telephone and video consultations and holding staff meetings virtually.

Section 75: Social value

3.19 The current iCaSH Service has very specialist clinical staff and offers opportunities to those not trained to develop their skills. Locating services in the north of the county in Wisbech has led to more employment opportunities for local residents which includes training to secure health qualifications.

Financial implications

Inflationary pressures

3.20 The current iCaSH Service has experienced considerable cost pressures because of the increased demand and inflationary pressures.

- Staffing Cost pressures: Although the service has received the Agenda for Change staff pay increases this does not include the uplifts to highly paid medical staff pay.
- Consumables cost pressures: SRH services (iCaSH) is a clinical service and has a high use of medicines, testing equipment including pathology costs and general clinic costs.

The forecasted overspend for 2023/24 was £525,000, (Cambridgeshire £350,000 and Peterborough £175,000) and a similar cost pressure is anticipated for 2024/25

Inflation calculator

3.21 In 2013 commissioning responsibility for SRH services was transferred to local authorities. Since then, the service has not received any inflationary uplifts. Additional income has been secured only for Agenda for Change and HIV Pre Exposure Prophylaxis (PrEP) uplifts

Using the Bank of England inflation calculator (Inflation calculator | Bank of England) we calculated the inflationary uplifts that could have been applied to the SRH services. The calculator uses the Consumer Price Index (CPI) inflation data from office of National Statistics from 1988 onwards. We applied the calculator to the Section 75 agreement price for both local authority areas as an indication of the level of the inflationary pressures experienced by services.

Table 4: Inflation calculator costs for current SRH (iCaSH) service

Local Authority	Section 75 2021/22 value	Section 75 2023/24 value if inflationary uplifts applied.	Cost of inflationary uplifts	Agenda for Change uplifts funded in 2024/25	Unfunded cost of inflationary uplifts
CCC	£3,429,427	£4,089,777	£669,350	£139,005	£530,345
PCC	£1,670,822	£1,992,545	£321,723	£56,420	£265,420

Treatment Services Current activity and costs

3.22 Analysis of patient data accessing the Service shows that although there is some small variation, the average CCC/PCC percentage split of patients is circa the 67%/33%. The funding allocation for 23/24 and clinic activity from each LA is shown in Table 3.

Table 5: 2023/24 SRH (iCaSH) contract costs showing CCC/PCC % contribution.

CCC/PCC 2024/25	Actual £	% of total contract value	Activity CCC/PCC clinics 22/23
CCC	£3,558,588	67%	47,683
PCC	£1,747,885	33%	23,421
Total	**£5,306,473**	**100%**	**71,104**

NB: Attendances refers to activity in a CCC/PCC clinic not by place of residence.

The proposed agreement is for six years with two break clause options at years four and five, starting April 1, 2025, and ending March 31, 2031. Table 6 shows the costing breakdown that is within the current funding envelope.

Table 6: Table 6: Section 75 total costs for 6-year agreement, 2025/31 with break options at years four and five. (no uplifts)

LA	25/26 £	26/27 £	27/28 £	28/29 £	29/30 £	30/31 £	Total 25/21 £
CCC	3,558,588	3,558,588	3,558,588	3,558,588	3,558,588	3,558,588	**21,351,528**
PCC	1,747,885	1,747,885	1,747,885	1,747,885	1,747,885	1,747,885	**10,487,310**
Total	5,306,473	5,306,473	5,306,473	5,306,473	5,306,473	5,306,473	**31,838,838**

NB: Funding allocation does not include any future Agenda for Change uplifts.

Cost pressures: mitigations

3.23 The annual forecasted cost pressure based 2023/24 is £525,000. (Cambridgeshire £350,000 and Peterborough £175,000).
The inflationary pressures described above led to CCS developing a plan for mitigating the cost pressures that included the following service changes which reduced the cost pressure to £242,000.

Table 7: Cost pressure mitigations

Service changes/innovation	Annual CCC cost savings	Annual PCC savings
Annual Cost Pressure	£350,000	£175,000
Express Test Capping (agreed service change creating saving)	£180,000	£54,000
Redirection of Hepatitis C testing to national platform (Service innovation creating saving)	£6,900	£1,800
Streamlining of Hepatitis B testing (Service innovation creating saving)	£5,700	£1,100
T2 Hybrid approach for online testing (Service innovation creating saving)	N/A	£8,500
NHSE HIV funded pressure	£25,000	N/A
Total savings from service changes and innovation & HIV	**£217,600**	**£65,400**
Savings shortfall pressure	**£132,400**	**£109,600**
Total shortfall pressure	**£242,000**	

However, there are also risks in the mitigations proposed by CCS. Capping of the express testing means that there are delays before people can get tested and treated. We have also had a small number of complaints since this was introduced at the beginning of 2024.

If the express capping was removed the value of the mitigations is decreased considerably and leave CCC with a funding gap of £312,400 and PCC with a funding gap of £163,600.

CCC currently has uncommitted Public Health uplift funding (2024/25). Sexual health services are mandated and therefore are a priority for funding especially in view of the increasing rates of infections.

In addition, some funding from out of area payments for sexual health services could be re-allocated to this service. The trend has generally been for these to decrease in recent years.

In the context of increasing rates of sexually transmitted infections and the associated risks of this funding shortfall options for increasing the allocation have been identified and are included in the recommendations found in this paper.

<u>Additional funding</u>

3.24 The following additional funding is proposed to be included in the current (2024/25) agreement and in the new agreement starting in 2025/26.

CCC
Unallocated from the 2024/25 Public Health Grant uplift: £200,000
From current out of area sexual health funding stream: £50,000
Total additional funding £250,000
Remaining funding gap: £62,400 (20%)

PCC
Total additional funding £130,880
Remaining Funding gap: £32,720

Approval for the use of the additional £200,000 public health grant uplift will be required from the Strategy, Resources and Performance committee. The finance monitoring report on this committee's agenda seeks the endorsement of this proposed investment into sexual and reproductive health services, subject to the approval of S,R&P committee.

The remaining funding gaps will be reviewed over 2024/25 to ensure that any improvements in inflationary pressures will be able to plug the outstanding gap. This is along with service developments to reduce costs.

It will include the provider reviewing its staffing models which was undertaken previously but in the light of new delivery approaches and pressures this will be revisited during 2024/25.

Table 8: Section 75 total costs for 6-year agreement, 2025/31 with break options at years four and five including inflationary uplifts

LA	25/26 £	26/27 £	27/28 £	28/29 £	29/30 £	30/31 £	Total 25/21 £
CCC	3,808,588	3,808,588	3,808,588	3,808,588	3,808,588	3,808,588	**22,851,528**
PCC	1,878,765	1,878,765	1,878,765	1,878,765	1,878,765	1,878,765	**11,272,590**
Total	5,687,353	5,687,353	5,687,353	5,687,353	5,687,353	5,687,353	**34,124,118**

NB: Funding allocation does not include any future Agenda for Change uplifts.

Prevention Service Costs

3.25 It is proposed that the Prevention Service is part of the Section 75 for the SRH Treatment service, but it is for CCC only. The recommended agreement length is six years with two break clause which would align it with SRH treatment service.

The 2024/25 contract value has been used to model the costs of the new contract in Table 8. It shows the total value of contract over six years along with the local authority split.

Table 9: Costs for 6-year agreement with break options at years four and five.

LA	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	6-year costs
CCC	£331,360	£331,360	£331,360	£331,360	£331,360	£331,360	£1,988,160

None of the current prevention funding will be re-allocated to the Children and Young People's Prevention Service as this will be funded from savings achieved through service redesign of the Healthy Child Programme.

Please note that PCC has withdrawn through funding pressures from commissioning a Prevention of Sexual Ill Health Service.

Table 10: Total recommended Section 75 value for Treatment and Prevention (CCC only) for 6 years 2025/31 with break options at years four and five

LA	25/26 £	26/27 £	27/28 £	28/29 £	29/30 £	30/31 £	Total 25/21 £
CCC	3,808,588	3,808,588	3,808,588	3,808,588	3,808,588	3,808,588	**22,851,528**
CCC Prev.	£331,360	£331,360	£331,360	£331,360	£331,360	£331,360	**1,988,160**
PCC	1,878,765	1,878,765	1,878,765	1,878,765	1,878,765	1,878,765	**11,272,590**
Total	**6,018,713**	**6,018,713**	**6,018,713**	**6,018,713**	**6,018,713**	**6,018,713**	**36,112,278**

Cost Pressure Management: Risk Assessment

3.26 There are a number of risks associated with not addressing the cost pressures and/or using a risk-based approach to managing the cost pressures. OBJ

- National reports and the local needs assessment clearly articulated the increasing trends in STI rates. These increases are impacting on services and are in the context of events such as the Monkeypox outbreak that require specialist staff.

- The main risk of not addressing the increased demand is untreated STIs, that lead to their increase and an even greater demand for the service.

- We have already received a number of complaints about the risk-based approach to offering on-line testing which can delay access to testing.

- Staff in the services are stretched and workforce attrition is another risk. Recruitment to the Service is difficult as the staff are specialists and require training and initial supervision when they start practicing.

- Cambridgeshire and Peterborough experienced substantial population growth between 2011-2021. A growing population - usual resident population grew by 9.2% (57,400) to 678,600 between 2011 – 2021. It is variable with all districts except East Cambridgeshire had population growth above the England average of 6.6%. The fastest population growth occurred in Cambridge City, with a growth of 17.6% (21,800 residents). The population is forecast to continue to grow across all districts, with 42,690 more residents in 2030. This will be across all age groups.

- This growth pattern is reflected in the higher demand for services in Cambridge City. Although the main demand for services arises from the 16- to 24-year-old age group there have been increases across all age groups.

4. Alternative Options Considered

4.1 There is no option to re-commissioning or a new agreement, as the current Section 75 will end on March 31, 2025, and it does not have any further extensions.

4.2 Given the level of need and the associated risks not recommissioning this service would present a threat to the sexual and reproductive health of the population and especially high-risk groups.

4.3 The option of re-commissioning a SRH treatment service for CCC alone was considered. However, this could potentially incur greater costs for CCC as it would be more difficult to manage any costs pressures due to the operation of the tariff system. This would mean paying tariff costs for Cambridgeshire residents accessing services in Peterborough. An additional consideration is that it enables early identification of infection trends across the two areas and where the risks occur, allowing a comprehensive response.

4.4 Public Health services are required to use the new Provider Selection Regime regulations to procure a new service. However, a Section 75 may still be used and is the recommended approach as it will enable the collaborative approach that commissioners have with the current provider to further develop the service. The needs assessment identified a number of development areas.

4.5 There is an option of commissioning the Prevention Service as a standalone service. This was considered but not adopted as it would not enable a strong working relationship between the treatment and prevention services. Working together the wider population prevention needs can be addressed and importantly the wider needs of high-risk groups can be more effectively met. Any signals regarding outbreaks can prompt an immediate prevention intervention.

4.6 Not addressing the inflationary pressures was considered but the risks of increased sexually transmitted infections as described in section 3.26 clearly supports additional funding.

5. Conclusion and reasons for recommendations

5.1 The recommendation that the new service should remain as a shared service between CCC and PCC is based on patient flows across the two areas and associated financial benefits through avoiding the additional costs of a tariff system. An additional consideration is that it enables early identification of infection trends across the two areas and where the risks occur, allowing a comprehensive response.

5.2 The recommendation for the use of a Section 75 agreement is because it builds on the collaborative working with the current provider, CCS, that has enabled considerable development of the Service. CCS has performed well and managed considerable cost pressures with any uplifts and other pressures. Evidence of this collaborative working is provided in the paper.

5.3 The recommendation to integrate prevention and treatment services through the Section 75

agreement would enable a strong working relationship between the treatment and prevention services. Working together the wider population prevention needs can be addressed and importantly the wider needs of high-risk groups can be more effectively met. Any signals regarding outbreaks can prompt an immediate prevention intervention. There are two caveats that must be reflected in the Section 75 agreement and carefully monitored. If there is increased demand for treatment services and cost pressures this could compromise the prevention funding envelope. Secondly as the Section 75 will only include prevention services for Cambridgeshire any indication of prevention activity in Peterborough must be addressed.

5.4 The recommendation to award an inflationary uplift is based on the risks to sexual and reproductive health leading to increased sexually transmitted infections and unplanned pregnancies if increased demand cannot be met.

6. Significant Implications

6.1 Finance Implications

These are described in full in 2.11

6.2 Legal Implications

The original recommendation from Procurement was to directly award the contract to the current provider under the new Provider Selection Regime Regulations (2023). This would be under the Direct Award Process C where an award may be made when there is no significant change to the service provision and the current provider is satisfying the requirements of the current contract. However, the addition of the Prevention Service would mean a significant change in the service. The recommended option subsequently changed to continuing with a Section 75 which is the current arrangement.
We have consulted with legal leads in CCC and PCC and the following statement supports the use of Section 75 partnering agreement.

Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 (“Regulations”) enable NHS bodies to exercise prescribed local authority health-related functions in conjunction with their own NHS functions. The power to enter into section 75 agreements is conditional on the following:

i. The arrangements are likely to lead to an improvement in the way in which those functions are exercised; and,

ii. The partners have jointly consulted people likely to be affected by such arrangements.

The Local Authority is required as part of its public health statutory duties to ensure that comprehensive, open access, confidential sexual health services are available to people in Cambridgeshire and Peterborough. This is set out in Regulation 6 of the Local Authorities

(Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

6.3 Risk Implications

- Any implications for procurement/contractual/Council contract procedure rules will be considered with the appropriate officers from these Departments and presented to the Adults and Health Committee before proceeding.
- Risks arising from not meeting the inflationary pressures are described in section 3.26.

6.4 Equality and Diversity Implications

A completed Equality, Impact Assessment (EqIA) form is attached (Appendix 1) to this report. Its main findings were based on the recent Sexual Health Needs Assessment that clearly articulated that certain groups experienced health inequalities which reflected their knowledge and access to services. The groups included sex workers, people experiencing homelessness, men who have sex with men and people with disabilities.

The new Prevention and Treatment Service will work with commissioners to ensure shape their services to better address the needs of these groups.

6.5 Climate Change and Environment Implications

The sexual and reproductive health prevention and treatment services have increasingly moved more digital and virtual services along with using postal services for some testing and treatment. This trend will be further developed. It impacts on the travel of both staff and patients.

In addition, the recommended Section 75 means that the current provider CCS, as an NHS organisation, is obliged to adhere to its commitment to net zero and CCS is committed to meeting the ambition. It has its own Green Plan that lays out a number of commitments which highlights some specific areas relating to these services.

7. Source Documents

7.1 Public Health Outcomes Framework: Public Health Outcomes Framework - OHID (phe.org.uk)

Sexual and Reproductive Health Profiles: Sexual and Reproductive Health Profiles - OHID (phe.org.uk)

Cambridgeshire and Peterborough Sexual and Reproductive Health Needs Assessment: Cambridgeshire and Peterborough Public Health – will be available on Insight.

Local Government Association: Breaking point: Securing the future of sexual health services. January 2024 Breaking point: Securing the future of sexual health services | Local Government Association

Cambridgeshire Provider Selection Regime Guidance: Procurement and Commercial Team: Finance and Resources - Provider Selection Regime - All Documents (sharepoint.com)