Notice of Meeting

Wellbeing and Health Scrutiny Board

Date & time	Place	Contact	Chief Executive
Monday, 13 March 2017 at 10.30 am	Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN	Andrew Spragg Room 122, County Hall Tel 020 8213 2673 andrew.spragg@surreycc.gov.uk	David McNulty

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Andrew Spragg on 020 8213 2673.

Elected Members
Mr W D Barker OBE, Mr Ben Carasco (Vice-Chairman), Mr Bill Chapman (Chairman), Graham Ellwood, Mr Bob Gardner, Mr Tim Hall, Mr Peter Hickman, Rachael I. Lake, Mrs Tina Mountain, Mr Chris Pitt, Mrs Pauline Searle and Mrs Helena Windsor

Co-opted Representatives:
District Councillor Patricia Wiltshire (Mole Valley District Council), Borough Councillor Tony Axelrod (Epsom & Ewell Borough Council) and Borough Councillor Darryl Ratiram (Surrey Heath Borough Council)

TERMS OF REFERENCE

The Wellbeing and Health Scrutiny Board may review and scrutinise health services commissioned or delivered in the authority's area within the framework set out below:

- arrangements made by NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;
- the provision of both private and NHS services to those inhabitants;
- the provision of family health services, personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- the public health arrangements in the area;
- the planning of health services by NHS bodies, including plans made in co-operation with local authorities, setting out a strategy for improving both the health of the local population, and the provision of health care to that population;
- the plans, strategies and decisions of the Health and Wellbeing Board;

- the arrangements made by NHS bodies for consulting and involving patients and the public under the duty placed on them by Sections 242 and 244 of the NHS Act 2006;
- any matter referred to the Committee by Healthwatch under the Health and Social Act 2012;
- social care services and other related services delivered by the authority.

In addition, the Wellbeing and Health and Scrutiny Board will be required to act as a consultee to NHS bodies within their areas for:

- substantial development of the health service in the authority's areas; and
- any proposals to make any substantial variations to the provision of such services.

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING: 17 FEBRUARY 2017 (Pages 1 - 14)

To agree the minutes as a true record of the meeting.

3 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter

(i) Any disclosable pecuniary interests and / or

(ii) Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member’s spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner)
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS AND PETITIONS

To receive any questions or petitions.

Notes:
1. The deadline for Member’s questions is 12.00pm four working days before the meeting (Tuesday 7 March 2017*)*.
2. The deadline for public questions is seven days before the meeting (Monday 6 March 2017*)*.
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 15 - 28)

The Scrutiny Board is asked to monitor progress on the implementation of recommendations from previous meetings. This is the last Wellbeing and Health Scrutiny Board meeting of the council year. Following the election, the Board will agree a Forward Work Programme for 2017/18.

6 A&E WINTER PRESSURES (Pages 29 - 46)

Following the high level of demand on NHS A&E units across the country and its effect on performance, the Board requested a response from each of the county's acute hospital trusts regarding their performance against the winter pressures.

7 INTEGRATED SEXUAL HEALTH SERVICES (Pages 47 - 72)

The Board has requested an update on the mobilisation of the integrated sexual health services contract from 1 April 2017

David McNulty
Chief Executive
Published: Friday, 3 March 2017

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

MINUTES of the meeting of the **WELLBEING AND HEALTH SCRUTINY BOARD** held at 9.30 am on 17 February 2017 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Monday, 13 March 2017.

Elected Members:
* present

Mr W D Barker OBE
* Mr Ben Carasco (Vice-Chairman)
* Mr Bill Chapman (Chairman)
Graham Ellwood
Mr Bob Gardner
* Mr Tim Hall
* Mr Peter Hickman
* Rachael I. Lake
* Mrs Tina Mountain
* Mr Chris Pitt
* Mrs Pauline Searle
* Mrs Helena Windsor

Ex officio Members:

Mrs Sally Ann B Marks, Chairman of the County Council
Mr Nick Skellett CBE, Vice-Chairman of the County Council

Co-opted Members:

* Borough Councillor Tony Axelrod, Epsom & Ewell Borough Council
* Borough Councillor Darryl Ratiram, Surrey Heath Borough Council
* District Councillor Patricia Wiltshire, Ashtead Common

Substitute Members:

Graham Ellwood
Mr Bob Gardner

Members In attendance

1/17 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Bob Gardner and Graham Ellwood. There were no substitutions.

2/17 MINUTES OF THE PREVIOUS MEETING: 10 NOVEMBER 2016 [Item 2]

The minutes were agreed as an accurate record of the meeting.

3/17 DECLARATIONS OF INTEREST [Item 3]

There were no declarations of interest made.

4/17 QUESTIONS AND PETITIONS [Item 4]

There were no questions or petitions submitted to the Board.

5/17 SURREY HEARTLANDS- THE DEVOLUTION OPPORTUNITY [Item 5]

Declarations of interest:

None

Witnesses:

David McNulty, Chief Executive, Surrey County Council and Chair, Surrey Heartlands Transformation Board
Matthew Parris, Evidence and Insight Manager, Healthwatch Surrey.

Key points raised during the discussion:

1. The Chair of the Surrey Heartlands Transformation Board explained that the primary thinking about the devolution opportunity had emerged from conversations regarding the Sustainability and Transformation Plans (STPs) and how health and social care systems can be improved by working together.

2. Members were informed that the Surrey Heartlands STP had been developing devolution plans since last spring, and that key partners had visited Manchester to hear about how health devolution had assisted their work.

3. Members acknowledged that devolution was a vehicle which would enable change to be delivered at speed and scale. The ambition of the STP was to reduce variation of care, quality and outcomes whilst delivering sustainable services within an ageing population with complex health needs. Members were informed that care would still vary based on individual medical needs, but that variation of care due to process would be reduced.

4. The Chair explained that given the complexities of the STP footprint, covering 11 organisations, effective partnership working with stakeholder groups, workforce and advocacy groups was key. He stated that public engagement was also important throughout the devolution process.

5. Members recognised that there were two approaches to devolution; namely the Cities and Local Government (CLG) Devolution Act and the NHS England (NHSE) Devolution Framework. It was explained that the STP were not going to follow either of these routes, instead agreeing upon a more pragmatic way forward that would achieve the devolution required.

6. Members acknowledged that bringing decision making closer to operational levels would allow for local accountability and control, whilst collaboration would enable a variety of expertise. The Chair explained that as part of the wider economic system, the devolution opportunity would allow for a closer fit between prosperity and health and wellbeing through the reduction of variations.

7. The Chair explained that a list of initial devolution asks had been discussed with but not yet agreed by central Government, and that the next steps would be dependent upon the drafted Memorandum of Understanding being signed off centrally, with a view to going live in April 2019.

8. Members were informed that whilst STPs were not considered to be the solution to social care funding shortfalls, health devolution would ensure funding and resource was used as effectively as possible rather than shifting pressures. It was explained that funding would be more accessible without the need to enter the bidding process, which would also have a positive impact on staff time.

9. Members acknowledged that health devolution would provide a big opportunity for Surrey County Council (SCC) with regard to improving services and sharing best practices. The Chair expressed the view that the success of the Orbis partnership provided complementary skills, and informed the Board that two key SCC officers were leading the work-streams for shared services and asset strategy for the devolution proposal.

10. Members questioned how the finances would be controlled across 11 organisations if devolution was achieved. The Chair explained that all partners faced pressures financially, and that there was always a danger of duplication when working collaboratively. He expressed the view that coming together would allow for better use of resources, reducing duplication and create solutions to reduce pressures system-wide.

11. Members noted that the STP would be dealing with over £1billion of commissioning activity and therefore they would need to ensure that the capacity was available. It was explained that Adult Social Care would still be required to fulfil Care Quality Commission (CQC) standards.

12. Members were informed that a number of housing and workforce opportunities were linked to the Three Southern Counties (3SC) devolution proposal, particularly in relation to affordable key worker housing, and that it was expected that the health devolution opportunity would adopt some of the thinking of the 3SC proposal.

13. Members raised concern regarding “the ability to set the adult social care precept at a rate that fully meets demand pressures” as one of the initial devolution asks, given Surrey’s lack of funding within social care. The Chair explained that this had not yet been agreed. He explained that any precept money would be ring-fenced for adult social care and it was necessary to plan ahead to ensure services were sustainable in the future.

14. Members questioned whether delegations of primary care would include taking control of GP practices. The Chair explained that devolved commissioning would not take over control of GP practices. Members were informed that the North West Surrey CCG already operated with this delegation of primary care, and that it would be useful if it was used across the entirety of the Surrey Heartlands footprint to allow better planning and to achieve balanced delivery of care needs.

15. Members were informed that the devolution proposals would provide many benefits to residents. The Chair explained that a lot of work had already been done to improve a number of care pathways including cardio-vascular and musculo-skeletal. The STP had also been working to embed mental healthcare provision within the plans. He went on to state that the proposals would provide partners with local control. This was exemplified with procurement, where proposals would allow partners to make local decisions, source equipment locally, enabling the decision-making process to be less constrained and more effective.

16. The Chair assured Members that whilst Surrey Heartlands STP only covered 85% of the county, there were meetings in place to discuss how benefits derived from health devolution could be accessed by 100% of Surrey's residents.

Recommendations

The Board recognises the opportunities presented in Surrey Heartlands' devolution proposals, and is supportive of the principles, and improvements it intends to unlock for Surrey residents, partnership agencies and the council.

It recommends:

- That a further update is brought regarding the governance of the STP as plans progress

In order to support the public in understanding Surrey Heartlands' vision, the Board recommends:

- That the STP seeks to clarify through case studies the benefits of devolution for the resident, and presents these to the Board at a future meeting.

6/17 IMPROVING STROKE CARE IN WEST SURREY - PUBLIC CONSULTATION [Item 6]

Declarations of interest:

None

Witnesses:

Dominic Wright, Chief Executive, Guildford and Waverley CCG

Giselle Rothwell, Head of Communications and Engagement, NW Surrey CCG
Vanessa Harding, Stroke Services Programme Manager
Matthew Parris, Evidence and Insight Manager, Healthwatch Surrey
Nick Markwick, Co-chair, Surrey Coalition of Disabled People.

Key points raised during the discussion:

1. The Head of Communications and Engagement began by informing Members that the public consultation had opened on 6 February 2017 and would be running for 12 weeks, with a closing date of 30 April 2017. She stated that local stroke groups, voluntary groups, patients and their carers were all being consulted, and that road-shows at hospitals and shopping centres had also been arranged as a way of engaging the wider public.

2. A witness raised concern regarding the response times for ambulances, particularly in the Waverley area. Members noted that whilst SECAmb were meeting the national target, response times in Waverley were below target. The Chief Executive for Guildford and Waverley CCG agreed that response times were of concern, and confirmed that the CCG was taking action within the contract. He also explained that given its rural location, the CCG was looking to help itself by utilising first responders from within the local community in recognition of the below-average response times.

3. Members expressed concern that the infrastructure in some areas meant that ambulances could get caught up at certain times of day. Witnesses were unable to comment on the satellite navigation system, although it was explained that SECAmb had a system in place to plan routes to avoid traffic calming measures.

4. Members noted that under current plans, Waverley stroke/cardiac patients were directly transferred to Frimley Park's hyper-acute stroke unit (HASU). The Chief Executive explained that he was aware that it was not a perfect solution, however it was within the key two-hour treatment time as recommended by the South East Coast Senate of Clinicians.

5. Members noted that service users and members of the public had stated that home visits for more than two months following a stroke were less important. It was suggested that more emphasis on aftercare and additional support within the community was important so that patients did not feel abandoned by the health system.

6. The Stroke Service Programme Manager explained that the premise of the new model was to reduce the length of stay in hospital. It had been recognised that community-based rehabilitation had led to faster recovery times. Early Supported Discharge (ESD) was currently available to 25% of patients, and the ambition was to increase this to 50%. There were plans in place to grow the team to enable the increased availability of ESD to be achieved.

7. Members questioned whether the 350 people that had been consulted in 2014-15 was a statistical representation. The Head of

Communications and Engagement explained that getting responses to consultation had sometimes proved difficult. She explained that the sample would be expanding to 1500 in order to test initial proposals, with all groups of characteristics across the population being consulted.

8. A witness from the Surrey Coalition of Disabled People explained that some people found it difficult to cross the county to access services. The Patient Transport Service had been problematic and therefore provision of multiple therapies in one location would be preferable. The Chief Executive assured the Board that the CCG intended to deal with the transport issues and identify accessible locations as part of this process.

9. Members questioned whether 12 engagement events was considered to be enough. The Head of Communications and Engagement explained that there was room in the diary for more events to be scheduled if required, although this would incur additional resourcing costs. She explained that the CCG intended to attend Patient Participation Groups as they generally enabled more discussion, thus allowing the CCG to be more responsive.

10. A Member suggested that the Board should take a pro-active approach, attending community centres and helping residents complete their consultation forms, enabling a better response rate and getting their voices heard. The Head of Communications and Engagement encouraged Members to signpost residents to the consultation by promoting it on social media or during conversations with their constituents.

Recommendations:

The Board recommends:

- That the Chairman follow up with the CCG and SECAmb on progress to address the response time issues faced in Waverley;

- That the Board receive a briefing on the consultation feedback received regarding support required following discharge, and the subsequent changes proposed in response to this.

The meeting was adjourned at 11:00am and resumed at 11:10am

7/17 SURREY AND BORDERS PARTNERSHIP - WARD CHANGE PROPOSALS [Item 7]

Declarations of interest:

None

Witnesses:

Justin Wilson, Medical Director, Surrey and Borders Partnership NHS Foundation Trust

Don Illman, Lead Governor, Surrey and Borders Partnership NHS Foundation Trust
Bill Chapman, Tim Hall and Tony Axelrod, Members of the working group
Matthew Parris, Evidence and Insight Manager, Healthwatch Surrey.

Key points raised during the discussion:

1. The Medical Director began by explaining that the ward re-location had taken place at the beginning of February and that the move had been successful. He explained that the new location provided a much improved environment for inpatients. Furthermore, the vast majority of nurses had transferred across to the Abraham Cowley Unit (ACU) and medical staffing levels had been augmented in order to support junior doctors. The Board was informed that the success of the move would be evaluated from a patient experience perspective and its impact on missing persons (MISPER) data would also be analysed.

2. The Lead Governor raised concerns that four nurses had left Surrey and Borders Partnership (SABP) as a result of the move, and a further four had found new jobs nearer to where they lived. He went on to state that whilst the physical environment at the ACU was fresh and newly refurbished, the rooms were still dormitories and therefore lacked a degree of privacy. The Medical Director pointed out that whilst the rooms were not individual en-suite rooms, the move had enabled wards to become single-sex rather than mixed-sex as they were at Epsom and that this was considered to be a significant improvement.

3. The Lead Governor told the Board that a consultation carried out in 2009 supported the case for three mental health hospitals within Surrey. The east of Surrey currently has no beds since the move to ACU was implemented. The Medical Director acknowledged the lack of facilities in the east of the county but explained that the consolidation of services onto fewer sites allowed for improved care provision to inpatients and consolidated medical support. Furthermore, he explained that SABP had a contract with Sussex to be able to use 14 beds at Langley Green if SABP reached their full capacity.

4. A Member of the working group commented on the conditions observed during his visit to the Epsom based wards prior to the move to the ACU. He told the Board that the doors to the entire unit, including the stroke unit above, had to be locked whilst staff moved inpatients to and from the servery area at mealtimes due to a shared public thoroughfare.

5. The Lead Governor raised concern that there was no public consultation regarding the decision to move the two wards from Epsom to the ACU, and that if this was a stroke or maternity ward being moved, there would have been public outcry. The Medical Director explained that the consultation carried out in 2009 supported the decision. The security and safety arrangements at the Epsom wards were of concern to the Trust, despite mitigations being implemented. Furthermore, patient experience survey results at Epsom were not positive and this helped form part of the decision to

relocate the services. The Medical Director explained that the decision was taken to implement the ward relocation as fast as possible after the opening of the Farnham Road hospital.

6. A Member of the working group endorsed the decision of the move, however raised concerns around the circumstances and speed at which the move was announced and implemented. He explained that the temporary move to the ACU would have been more acceptable if a decision had been made about the location of the second mental health hospital site, given that this will take approximately five years to build.

7. Members sought clarity regarding the current status of the second hospital site. The Medical Director explained that the previous consultation, in 2009, indicated a preferred geographical outcome of three mental health hospitals for Surrey, although SABP would prefer a two hospital solution based on the number of beds required. He stated that there were strategic options with varying costs for sites in Redhill, Chertsey, West Park and Epsom, although no decisions would be made until after the consultation process. The Medical Director explained that the consultation for the second site had been scheduled to begin in early 2017, however this had not yet commenced and that the commissioners would be leading on the consultation programme.

8. The Board raised concerns regarding travel arrangements to the ACU for the friends and families of inpatients. A Member of the working group explained that he had travelled by public transport to the ACU to test accessibility and that his journey was manageable, however he recognised it could be a struggle dependent on where they were travelling from. Another Member enquired as to whether a minibus service from Woking or Chertsey stations had been considered by the Trust to mitigate travel concerns. The Medical Director explained that a shuttle-bus service was in place for staff, however for patient visits, due to low volumes of numbers and the frequency of visits that generally took place, taxis would be the most cost-effective option.

9. Members were concerned that families visiting from the East of Surrey could face a long commute and that this may have a negative effect on patients as visits could become less frequent. The Board was assured that this impact would be measured.

10. The witness from Healthwatch Surrey explained that recent visits to safe havens in Surrey had identified that service users had concerns about funding cuts for safe haven services as of April 2017. The Medical Director stated that the Trust was committed to supporting the work of the safe havens, as they provided a cost-effective way of improving bed availability and a positive impact on service users.

Recommendations

- That the Trust review the process by which it plans future ward relocations, in order to improve its change management practices.

- That the Trust set out timescales for consultation and anticipated impact on current services, and that the Board receive an update during consultation.

- That the Trust produce a travel plan to demonstrate how people and their families will be supported to access the Abraham Cowley Unit.

- That the Trust provide additional resource to support people who use the wards to access Skype and other communication tools, where appropriate.

- That the Trust monitor family and patient feedback following the move and provide a summary of key themes for the Board in six months' time.

- That the Trust report the impact on Missing Person rates to the Board in six months' time.

- That the Trust and commissioner clarify the position on funding for the safe haven in Epsom.

8/17 CHAIRMAN'S ORAL REPORT [Item 8]

The Chairman provided an update to the Board regarding business undertaken since the previous meeting. A copy is attached as an annex to these minutes. The Board noted and accepted the Chairman's report.

9/17 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 9]

The Board reviewed the recommendations tracker and forward work programme. There were no comments.

10/17 DATE OF NEXT MEETING [Item 10]

The Board noted that its next meeting would be held on Monday 13 March at 10:30am.

Meeting ended at: 12.12 pm

Chairman

Chairman's Report to the Wellbeing and Health Scrutiny Board – 17 February 2017

Winter Pressures

As many of you are aware, the NHS has experienced a system-wide challenge in terms of demand over the winter season. While this was anticipated and planned for, I do feel we cannot afford to accept it as the normal state of being for our health services. I feel the Board in particular has a role in specifically understanding how the current crisis is impacting on our residents, and then considering how we can support our colleagues across the public sector in improving patient experience and outcomes.

In order to support this, I've written to each of our acute hospital providers with a number of key questions. The intention of these letters is to evidence what the impact has been across Surrey, and whether any key themes have emerged over this period. It is vital that we as a scrutiny board understand what the long-term strategic challenges to the health service mean for our residents.

The Board will be reviewing the responses to these requests at the next meeting on 13 March and I have invited each Trust to send a representative. I hope we can work collectively to understand the challenges faced, and identify ways we can act as a critical friend while supporting decisions that will mean a better health service in the long term.

South East Coast Ambulance Service (SECAMB)

Following an adverse assessment by the Care Quality Commission and a Quality Summit held on 28 September 2016, SECAMB was placed in Special Measures by NHS Improvement for an initial six month period.

You will recall that we established a regional sub-group with the other five health scrutiny committees across the region for SECAmb services. The first meeting of this sub-group was held on 20 December 2016, and the minutes of the meeting are attached to the recommendation tracker. I ask that the Board note the contents of these minutes, and raise any questions with me or Bob Gardner to take forward on their behalf.

The next meeting of the regional sub-group will be held on 20 March 2017. We have asked to have a detailed report on progress on the two improvement work-streams we felt most greatly impact on patient experience, namely Performance, and Clinical Outcomes. We will also hear how the Trust has progressed against a number of "must-do" actions required by the CQC.

Frimley Health Sustainability and Transformation Plan (STP)

On 29 November, I represented the Board at a Frimley Health STP Broader Involvement Event. I had useful discussions with the leaders of several of the work-streams identified in the Frimley Health STP.

My impression is that work is progressing well, and is based on rolling out the existing successful models of care to the complete footprint. There seem to be no major changes in the offing.

Surrey Heartlands Sustainability and Transformation Plan

The Board will be hearing again today from the Surrey Heartlands STP whose footprint encompasses approximately 85% of Surrey residents.

The STP is providing thorough information through its web-site and regular news reports. Several of our Members have taken part in excellent stakeholder engagement events. There is a further system-wide leadership event scheduled for 7 March 2017.

Sussex and East Surrey Sustainability and Transformation Plan

Members may recall that at the previous Board Meeting of 10 November we heard that the footprint for the Sussex and East Surrey STP incorporates 27 different organisations and covers eight CCGs. It has therefore been divided into three place based plans of which the Central Sussex and East Surrey Alliance (CSESA) Plan includes East Surrey.

On 20 January, I joined HOSC Chairmen and Officers from East Sussex, West Sussex and Brighton and Hove to receive a presentation from Geraldine Hoban who leads on the CSESA. The presentation materials are included at Annex A.

Focussing predominantly on the interests of East Surrey residents, my conclusions from the presentation and discussions at this meeting were:

- The CSESA Plan is much less developed than those of the other two Surrey STPs.
- In response to the overall Sussex and East Surrey STP Plan submitted in November, NHS England and NHS Improvement have insisted that urgent action is taken to assess and address the future capabilities of the Royal Sussex County Hospital, Brighton. A task force from Carnall Farrow is carrying out the assessment and the HOSC Chairman will meet again when the findings are available, likely towards the end of March.
- The financial position for the overall STP which was already bad, is worsening. The overall prospects for improvement to the health and social care services in the S&ES footprint are problematic.

- In East Surrey the prospects are more positive with implementation of the Multi-Speciality Community Provider (MCP) model progressing well. An assessment of the challenges for CSESA are listed in Slide 9 of Annex A. We will invite Geraldine to a future Board meeting so that Members can scrutinise how things progress.
- There seems to be no question of any Acute Hospital closures within the S&ES footprint since it is recognised that there are already insufficient hospital beds within the footprint, a situation which will likely worsen during the later stages of redevelopment of the Royal Sussex County Hospital, Brighton.
- East Surrey Hospital is already providing elective (non-emergency) care for patients from what would normally have been the Brighton Hospital catchment. The level of additional load may well increase later.

I intend to meet leaders of East Surrey CCG to investigate matters further and in particular to understand how they intend to protect their residents against any possible harm from the extra workload at East Surrey Hospital.

Epsom Hospital

It would be wrong to ignore public concern over the uncertainty for the future of Epsom Hospital. Following press speculation in November, Chris Grayling, MP responded by publically stating that there was then no plan to close Epsom Hospital and promising that if one came forward, then full public consultation would take place.

Several Members and I will be meeting Daniel Elkeles (Chief Executive of Epsom and St Helier Hospital Trust) and Claire Fuller (Chief Executive of Surrey Downs CCG) on 23 February and will report back to our next WHSB Meeting on 13 March.

Members may recall that the Board last received a Report on the Surrey Stroke Service at our Meeting of 14 September. Claire Fuller will be providing us with an update on 23 February.

NHS Right-Care

I would like to draw attention to the work of NHS Right-Care. Its role is to give clinical commissioning groups (CCGs) and local health economies practical support in gathering data, evidence and tools to help them improve the way care is delivered for their patients and populations.

NHS Right-Care has recently published updated 'Commissioning for Value - Where to Look Packs':
https://www.england.nhs.uk/rightcare/intel/cfv/

These packs are produced for each of the individual CCGs, and have also been aggregated into packs for each of the STPs.

The intention is that by using this information each STP area will be able to ensure its plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes, resource allocation and reduction of inequalities. NHS England, Public Health England and CCGs have legal duties under the Health and Social Care Act 2012 with regard to reducing health inequalities; and for promoting equality under the Equality Act 2010. One of the main focuses for the Commissioning for Value work is in reducing variation in outcomes. Commissioners ought to use the packs, and the supporting tools, to drive local action to reduce inequalities in access to services and in the health outcomes achieved.

The Board will no doubt have an interest in how each of the STPs use these data to influence their change programmes.

WELLBEING AND HEALTH SCRUTINY BOARD
ACTIONS AND RECOMMENDATIONS TRACKER – UPDATED March 2017

The recommendations tracker allows Board Members to monitor responses, actions and outcomes against their recommendations or requests for further actions. The tracker is updated following each Scrutiny Board. Once an action has been completed, it will be shaded out to indicate that it will be removed from the tracker at the next meeting. The next progress check will highlight to members where actions have not been dealt with.

Scrutiny Board Actions & Recommendations

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
SC077	Children's Mental Health [Item 6]	It also recommends that NHS England provide details on the outcome of specialised CAMHS commissioning and in particular how this will deal with adverse travelling times experienced by Surrey residents The Board recommends that commissioners and SABP return to the Board in 2017 with a report that outlines the new CAMHS performance against Key Performance Indicators. This should include the time taken for children to be referred, assessed and treated, the type of interventions they receive and what differences these have made	Head of Mental Health Specialised Commissioning, NHS England South	The Chairman will write to witnesses asking for a response to this recommendation, and confirmation of when would be an appropriate time to report on performance in 2017.	*March 2017*
SC080	Health Inequalities in Surrey Workshop [Item 9]	The Chairman and Vice-Chairman will meet with the Public Health Consultant to develop the Board's scrutiny of the three areas identified by Members.	Deputy Director of Public Health	*Meeting to be scheduled*	*March 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
SC084 3 May 2016	Surrey and Sussex Healthcare and Virginia Mason Institute Collaboration Report	The Board invites witnesses to come back to this Board and update on progress. The Board recommends: o That the report covers the improvement projects with hard data on the target improvements e.g. on referral times		*This will be added to the proposed forward work programme for 2017/18.*	*May 2017*
SC085 7 July 2016	SECAmb update	That progress updates from the Strategic Partnership Board are shared with the Board as appropriate That SECAmb and representatives with the Board recommence quarterly quality review meetings That the Chairman meets with SECAmb in three months for an update on progress. That SECAmb provides a report in six months outlining the following: • Progress against action plan • Key priorities for the next six months • Evidence of improvements brought about as result of changes in the complaint procedure	Acting Director of Commissioning, South East Coast Ambulance Trust	*A regional task group has been agreed. The first meeting of this group was held on 20 December 2016, and minutes shared at the last meeting. A further meeting is planned in March 2017.*	*March 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
SC086 7 July 2016	24/7 Assessment and treatment review, second mental health hospital.	That a further update with the final proposals for hospital plans is brought to the Board following the consultation	Medical Co-Director, Surrey and Borders Partnership Foundation NHS Trust	*The Board's scrutiny officer has written to the Trust asking for confirmation of timescales.*	*This item was provisionally scheduled for March 2017*
SC088 14 Sep 2016	Next steps for Surrey Stroke Services	That an update provided to the Board following the final decision by the committee in common on 6 October 2016 That this update demonstrates how consultation activity will engage with identified high risk groups, and those families and patients involved with ongoing care following a stroke	Chair, Surrey Stroke Review	*Stroke services in the west of Surrey are now subject to a consultation and this was considered as an item at the February 2017 meeting. Commissioners for stroke services in the east of Surrey are in discussions with providers, and will bring an update to a future meeting.*	*February 2017.*
SC089 14 Sep 2016	GW CCG: Adult Community Health Services Update	That Guildford and Waverley CCG provide further details as to the engagement activities with patients and families undertaken through the procurement process, how this influences the procurement process, and how this will help inform co-production over the	Deputy Director of Clinical Commissioning, Guildford & Waverley CCG Senior Commissioning	*An update has been requested, and will be circulated to the Board.* *A further formal update is due*	*March 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		next 12 months That Guildford and Waverley CCG return to the Board with an update following mobilisation That Guildford and Waverley CCG consider developing a public-facing scorecard that will enable residents to understand how providers are monitored and how they are performing	Manager, Guildford & Waverley CCG Deputy Director of Adult Social Care, Surrey County Council	*post-mobilisation.*	
SC090 14 Sep 2016	NW Surrey CCG: Adult Community Services Procurement	That the Chairman give further consideration as to the Board's role in scrutinising and monitoring the questions of continuity and consistency across Adult Community Services in Surrey; That NW Surrey CCG consider developing a public-facing scorecard that will enable residents to understand how providers are monitored and how they are performing; That NW Surrey CCG share lessons learnt through the disaggregation and mobilisation process with the Board, other CCGs and STP leads;	Chairman of the Board Acting Associate Director of Contracts, NWS CCG	*This will be considered following the mobilisation period for the new contracts.* *An update has been requested, and will be circulated to the Board following mobilisation.*	*June 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		That NW Surrey CCG return to the Board with an update following mobilisation.		*A further formal update is due post-mobilisation.*	
SC091 14 Sep 2016	NW Surrey CCG: Re-Commissioning of Patient Transport Service	That NW CCG clarify the governance arrangements around integration with community transport; That NW CCG provide a further update to the Board following transition and contract mobilisation.	Interim Ambulance Programme Manager, NWS CCG	*A response has been received from the CCG and is attached to this tracker* *Update due post-mobilisation*	*May 2017*
SC092 14 Sep 2016	NW Surrey CCG: Re-Commissioning of NHS 111.	That, in order to assist with public engagement, NW Surrey CCG seek to distil the vision for NHS 111 procurement into a clear statement about what they wish to achieve; That NW Surrey CCG clarify how they will seek to engage vulnerable and disadvantaged groups	Interim Ambulance Programme Manager, NWS CCG	*A response has been received from the CCG and is attached to this tracker*	*March 2017*
SC093 10 Nov 2016	Joint procurement of Children's Community Health Services	That the CCG and provider develop a public facing performance score-card in order to help residents understand how services are delivering;	Sarah Parker, Director for Children's commissioning, Guildford and Waverley CCG	*This will be considered following the mobilisation period for the new contracts.*	*July 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		That the CCG return in 12 months, with an update on how the performance data of the newly commissioned services has supported further strategic commissioning for future years; That the CCG provide a briefing on how the new commissioning arrangements will work with the relevant partners to ensure smoother transition between childhood and adulthood for community health services; That the Board gather evidence from relevant commissioning bodies as to how they stimulate and support the provider market in order to ensure appropriately competitive tendering.		*An update has been requested, and will be circulated to the Board.* *A further formal update is due post-mobilisation.*	
SC094 10 Nov 2016	Sustainability and Transformation Plans progress update	That each footprint provide the Board with an update on progress in delivery of the STPs, with a particular focus on how the Board may contribute to the plan success; That each STP define and share its governance arrangements as a matter of priority, with a particular emphasis on improving public understanding around		*The Chairman has written to each of the STP leads sharing the recommendations. Follow-up items will be scheduled with each STP as the plans develop. The Board will take forward these*	*May 2017*

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Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		how decisions are made within the STPs; That STPs seek to engage with the relevant district and borough councils in order to improve public awareness, and report back to the Board on planned and future activity in this respect; STP- specific recommendations: **Surrey Heartlands** That the Board receive future updates on • plans for Epsom and St Helier • the development of community hubs. **Frimley** That the STP seek to engage more widely with patient and carer participation forums, and provide a further briefing of how this activity has influenced the development and delivery of the plans **Sussex and East Surrey** That the STP share the place-based plan relevant to Surrey with the Board, when available for scrutiny.	Julia Ross, Surrey Heartlands STP lead Tina White, Frimley STP programme director Amanda Fadero, Executive Board Member, Sussex and East Surrey STP programme	*recommendations in May 2017.*	

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
SC095 17 Feb 2017	Surrey Heartlands: The Devolution Opportunity	That a further update is brought regarding the governance of the STP as plans progress; That the STP seeks to clarify through case studies the benefits of devolution for the resident, and presents these to the Board at a future meeting	David McNulty, Chair of the Surrey Heartlands Transformation Board, Julia Ross, STP lead		
SC096 17 Feb 2017	Stroke Review- Public consultation of West Surrey	• That the Chairman follow up with the CCG and SECAmb on progress to address the response time issues faced in Waverley; • That the Board receive a briefing on the consultation feedback received regarding support required following discharge, and the subsequent changes proposed in response to this;	Chairman of the Board Giselle Rothwell, Head of Comms and Engagement, North West Surrey CCG,	*The Chairman will raise this as a question to the SECAmb regional sub-group on 20 March 2017, and report back.* *The consultation period is running over the spring, and a briefing will be circulated following its conclusion.*	*May 2017*
SC097 17 Feb 2017	Surrey & Borders Partnership: ward change proposals	• That the Trust review the process by which it plans future ward relocations, in order to improve its change management practices	Andy Erskine, Director of Mental Health services, SABP.	*These recommendations have been shared with the Trust, and a response is*	*May 2017*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		• That the Trust set out timescales for consultation and anticipated impact on current services, and that the Board receive an update during consultation; • That the Trust produce a travel plan to demonstrate how people and their families will be supported to access the Abraham Cowley Unit. • That the Trust provide additional resource to support people who use the wards to access Skype and other communication tools, where appropriate. • That the Trust monitor family and patient feedback following the move and provide a summary of key themes for the Board in six months' time. • That the Trust report the impact on Missing Person rates to the Board in six months' time.		*being prepared.*	

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Progress Check
		• That the Trust and commissioner clarify the position on funding for the safe haven in Epsom			

Item and Reference: North West Surrey CCG: Re-commissioning of the Patient Transport Service, SC091

Date: 14 September 2016

Recommendations:

1. That NW CCG clarify the governance arrangements around integration with community transport;
2. That NW CCG provide a further update to the Board following transition and contract mobilisation.

Response to Recommendation 1:

The Validation Process for Community Transport Providers is outlined below:

- Each provider South Central Ambulance Service (SCAS) use, regardless of ad hoc or contracted activity goes through a validation process before they are set up and used to support NEPTS activity:

Insurance

- Insurance cover appropriate to delivery of service

Employee information checks

- Uniforms and IDs
- DBS Checks
- Driving License checks
- Staff Competency

Vehicle/Equipment/Premises Checks

- Safely and securely convey patients
- Vehicle checks – MOT, Road Worthiness
- Equipment checks
- Cleanliness and safety checks

Training/Health and Safety Requirements

- Training records up to date and monitored

Corporate information

- Standard operating procedures and policies reviewed/evidenced.

Each Provider has to meet the above requirements to undertake patient journeys. All Community Transport Providers involved in our contract have passed this validation process. The process is audited on a yearly basis, however if there are

any concerns raised as part of an incident/complaint, then SCAS will do a spot check and if necessary agree plans to improve the position or remove the provider from the approved provider list - but only where improvements cannot be made to a satisfactory level and patient safety is compromised.

Response to Recommendation 2:

The contract is due to go-live on 1st April 2017, and it is proposed that the Board is provided with an update to the Board at the end of Quarter 1 – end June. This would allow for a more comprehensive account of the new service, its performance and improvements, once it has had a chance to settle in.

Lyn Reynolds, Acting Associate Director of Strategic Commissioning, North West Surrey CCG.

Item and Reference: North West Surrey CCG: Re-commissioning of NHS 111 service, SC092

Date: 14 September 2016

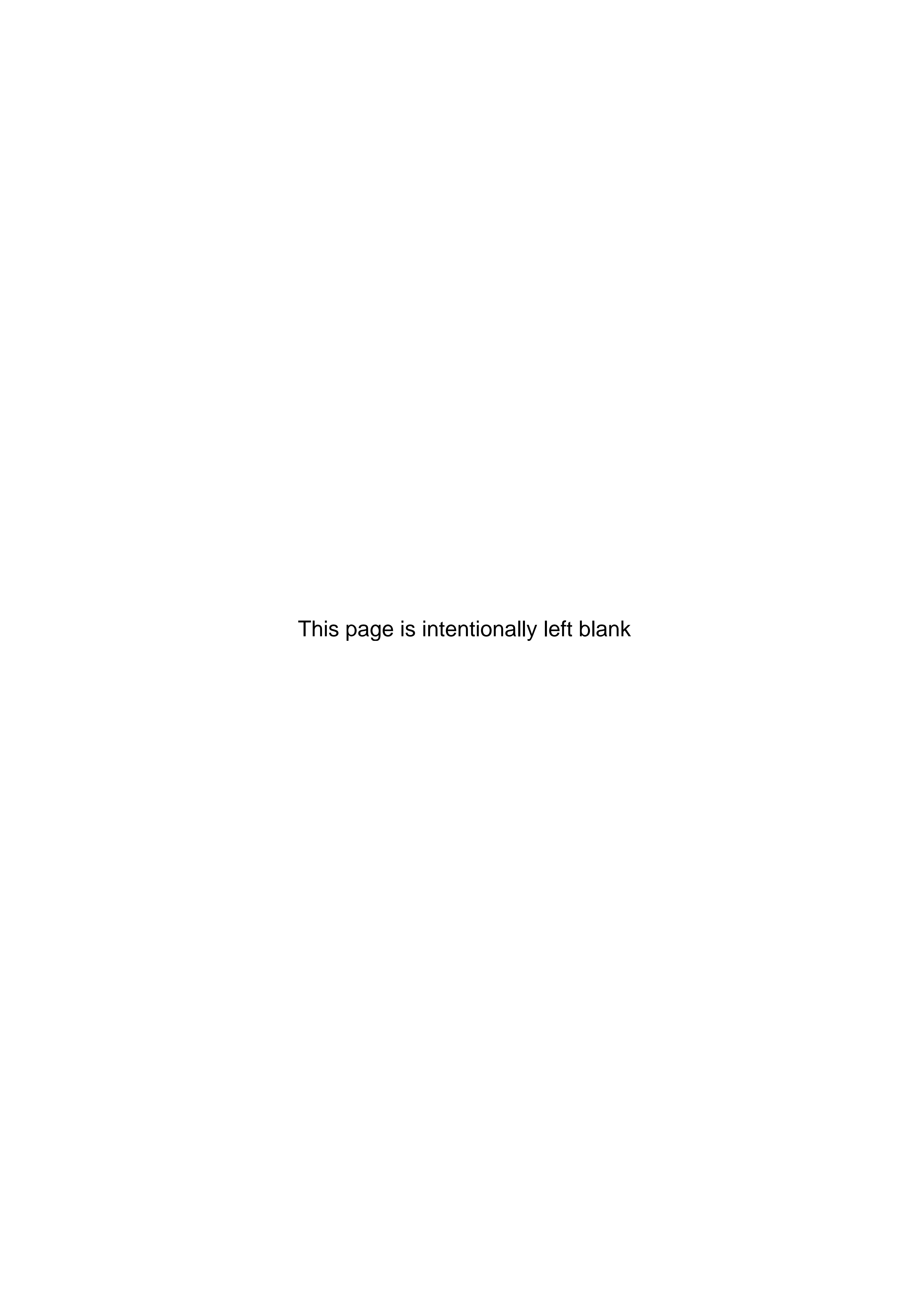
Recommendations:

1. That, in order to assist with public engagement, NW Surrey CCG seek to distil the vision for NHS 111 procurement into a clear statement about what they wish to achieve;
2. That NW Surrey CCG clarify how they will seek to engage vulnerable and disadvantaged groups

Response:

Our Patient and Carer Advisory group meets on a regular basis and Healthwatch Surrey are now joining these meetings and assisting us in our engagement campaign. Collectively we will devise a clear statement on what we wish to achieve to assist with our public engagement as suggested by the Board. This work is currently on going and the engagement campaign is likely to commence from May onwards. We are finalising our stakeholder mapping which includes equality and diversity leads from key stakeholders. Healthwatch Surrey have also agreed to disseminate information via their database/existing channels of vulnerable/disadvantaged groups and other stakeholders.

Lyn Reynolds, Acting Associate Director of Strategic Commissioning, North West Surrey CCG.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Wellbeing and Health Scrutiny Board
13 March 2017

A&E Winter Pressures

Purpose of the report: Performance Management

Following the high level of demand on NHS A&E units across the country and its effect on performance, the Board requested a response from each of the county's acute hospital trusts regarding their performance against the winter pressures.

Introduction

1. The Chairman of the Wellbeing and Health Scrutiny Board sent a letter to the Chief Executives of all of the county's acute hospital trusts, requesting responses detailing their A&E performance against recent pressures faced over the winter period.

Questions

2. The letter sent to each of the acute trusts is attached at **annex 1**. It asked for responses to five key questions;
   a) How did you work with partners in health and social care to manage the increased demand in A&E in December 2016 and January 2017?
   b) What plans are in place in your area to manage such a spike in demand should it re-occur in 2017/18?
   c) What, in your view, needs to be done to ensure that A&E is used appropriately in the future?
   d) What are the risks to A&E performance in your area?
   e) Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?

Responses

3. The responses received from each of the acute trusts are attached at **annex 2**.

Recommendations:

The Board are asked to note the responses from the acute trusts and acknowledge their performance whilst faced with increased demand over the winter period.

Report contact: Andrew Spragg, Scrutiny Officer, Democratic Services

Contact details: andrew.spragg@surreycc.gov.uk, 020 8213 2673

Sources/background papers:

Annex 1

Bill Chapman
Chairman
Wellbeing and Health
Scrutiny
Surrey County Council

Sent via email

22 February 2017

Dear Health and Care Commissioners and Providers,

Accident & Emergency Performance during Winter Pressures

In past years the Health Scrutiny Committee has considered evidence from a number of providers and commissioners on the impact of demand during the winter months.

I am aware that similar issues have been faced this year, and would like to invite your views as to how the Surrey-wide system has responded to this demand.

I am, therefore, writing to you to request your views on the following questions:

1. How did you work with partners in health and social care to manage the increased demand in A&E in December 2016 and January 2017?
2. What plans are in place in your area to manage such a spike in demand should it re-occur in 2017/18?
3. What, in your view, needs to be done to ensure that A&E is used appropriately in the future?
4. What are the risks to A&E performance in your area?
5. Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?

As per the regulations covering local authority health scrutiny I am asking you to respond within 28 days of the date of this letter.

The intention would be to present these responses to the Board on 13 March 2017. We would also like to invite you to attend this meeting. It is scheduled for 10:30am in the Ashcombe Suite, County Hall, Penrhyn Road, Kingston-upon-Thames, KT1 2DN.

I appreciate you continue to have several constraints on your time during this busy period, so please contact me if you feel that you are unable to attend the meeting or will need to respond at a later date.

Please can you send your response(s) or any queries regarding the logistics of the meeting to the Board's scrutiny officer, Andy Spragg by email at andrew.spragg@surreycc.gov.uk

Yours sincerely,

W. S. Chapman

Councillor Bill Chapman
Chairman, Surrey Wellbeing and Health Scrutiny Board

Annex 2

St Helier Hospital
Wrythe Lane
Carshalton
Surrey SM5 1AA

Tel: 020 8296 2267
Web: www.epsom-sthelier.nhs.uk
Email: Daniel.elkeles@esth.nhs.uk

17th February 2017

Dear Councillor Chapman

Thank you for your letter dated 25th January 2017 requesting information in relation to Accident and Emergency performance during winter pressures.

I am pleased to confirm that Epsom and St Helier University Hospitals NHS Trust is reporting a year to date performance of 95.15% against the 95% 4 hour operational standard. The Trust is one of a very few hospitals nationally who is successfully delivering this standard.

Our approach to successfully delivering the 4 hour operational standard has focussed on managing an increase in demand through our emergency departments and on streamlining our inpatient systems and processes to ensure that we are able to create available capacity for patients who require admission to a hospital bed.

We have worked closely with partners in health and social care to manage the increased demand to our emergency departments. At Epsom we have established Epsom Health and Care which is a partnership alliance involving GP Health Partners, CSH Surrey (community provider), Surrey County Council, and the Acute Trust. This has enabled us to develop an enhanced @home service which is a single, integrated service providing people over the age of 65 at serious risk of admission with an alternative to an inpatient stay. The service also provides supported discharge and 'discharge to assess' interventions for those people where admission is unavoidable, which in many cases will be an alternative to a longer hospital stay.

At St Helier Hospital we have a multi-disciplinary community in-reach team who assess patients presenting to the emergency department to support admission avoidance for appropriate patients.

Both hospital sites benefit from co-located GP services so that patients presenting to the emergency department with a minor illness/injury can be seen by a primary care clinician. This means that clinical staff in A&E can focus on treating patients with more serious and life threatening conditions.

In order to support flow through our emergency departments we have established a dedicated hub for GP accepted/medically accepted patients on both acute medical units. This means that patients can transfer directly to the hub for initial medical assessment rather than wait in our emergency departments. The units are consultant-led so patients benefit from an early senior clinical review with a focus on admission avoidance for appropriate patients.

At St Helier Hospital we have established a medically fit for discharge ward which is led by a nurse consultant with input from local GPs, social care, and community service providers. This is an area where we cohort all of our medically fit patients which supports a multidisciplinary approach to complex discharge planning. Our teams can focus their efforts in one area rather than across multiple wards and departments, therefore, supporting a reduction in length of stay.

In order to support the implementation of new systems and processes we have embarked on a non-elective patient flow transformation programme which commenced in April 2015. This involved implementation of lean methodology across our inpatient emergency bed base and clinical site teams across both hospital sites. The methodology involved implementing 10 tools and techniques over a 12-week period aimed at improving patient flow through the hospital and ensuring that patients were admitted to the right bed, first time. The programme is now being rolled out in Pharmacy. Progress in relation to the programme is monitored through our patient flow steering group and we have a KPI performance dashboard to assess overall effectiveness, which has resulted in less daily discharge variability and a reduction in medical and surgical outliers compared to the same time period last year.

In addition, we have a very robust operational approach to managing flow through the hospital. We have redesigned our site-specific bed meetings ensuring that there is whole hospital involvement and engagement in the management of emergency demand. We also have twice daily (more often if required) director-led cross-site conference calls every day in order to assess the situation on both hospital sites and put in place early actions to maintain effective patient flow. We have also put in place additional consultant and junior doctor support over the weekend period to support the assessment of patients who are appropriate for discharge.

We have established an urgent care board with wide clinical involvement to focus on key actions required to further improve non-elective systems and processes. We have a long list of other initiatives that we have implemented/are implementing and monitor progress against these schemes on a monthly basis.

It is likely that we will continue to see an increase in emergency demand throughout 2017/18 and the changes that we have put in place throughout this year will mean that we are better

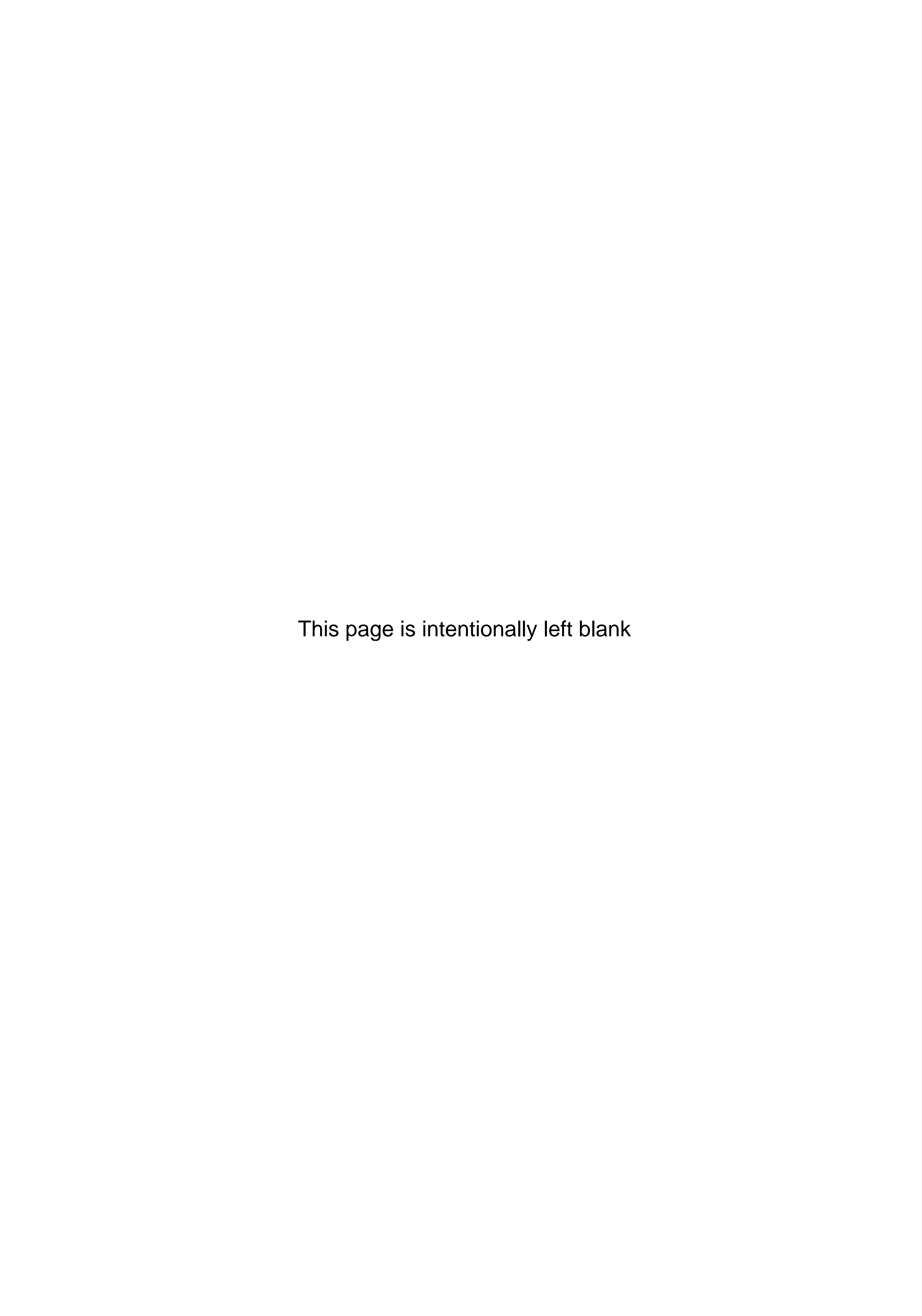
able to successfully manage a future increase in demand. In addition, we continue to work closely with our health and social care partners to further develop existing systems and processes to better manage admission avoidance and complex discharge. An example of this is a focussed piece of work in the Sutton locality which supports the implementation of 'discharge to assess' resulting in complex discharge planning assessments taking place in the patients home rather than in hospital, resulting in a shorter length of stay for appropriate patients.

We continue to remain focussed on maintaining our strong delivery of the 95% 4 hour emergency department operational standard and working with external partners to further improve existing systems and processes for our patients. We look forward to discussing this in more detail at the Health Scrutiny Committee on 13th March 2017

Yours sincerely

Daniel Elkeles

Chief Executive Officer



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Annex 2

Royal Surrey County Hospital NHS
NHS Foundation Trust

Councillor Bill Chapman
Chairman
Wellbeing and Health Scrutiny Board
Surrey County Council

Egerton Road
Guildford
Surrey
GU2 7XX

9 February 2017

Dear Councillor Chapman

Thank you for your letter of 25th January 2017 in recognition of the impact of demand on the hospital during the winter months.

I have answered each of your questions in turn:

1. How did you work with partners in health and social care to manage the increased demand in A&E in December 2016 and January 2017

We are part of the Guildford and Waverley Local A&E Delivery Board, which is a forum that meets regularly to address the issues associated with A&E; for example this might include the impact of social care provision on discharge out of the hospital and occupancy in the hospital, which in turn would have a knock on effect on the front door of A&E. This forum has attendance from all local partners involved in health and social care and when demand in the system was really significant in December and January extra meetings were called to see what responses could be made. This process is in addition to daily operational phone calls and the usual contact between practitioners.

2. What plans are in place in your area to manage such a spike in demand should it re-occur in 2017/18?

I believe that one of the biggest challenges for the health and social care system is to have really effective plans in place to meet the annual demand in winter with its spikes. This planning needs to take place on three levels:

- Strategic – linked to the STP
  This level of change will take more than one year and some change in investment
- Annual
  The Annual plan for winter needs to be agreed and signed off in local systems as early as possible in the year to allow for commissioning and providing of additional capacity. Additional capacity will be needed through the peak months of winter and should be ready to deploy when needed, in preference to scrabbling around for additional capacity and staffing at premium rates when the spikes emerge.
- In crisis
  Linked to the point above reserving some funding and having identified additional capacity, accessible when a crisis is reached should be part of the planning process. Equally the Operational Pressures Escalation Levels Framework should be followed and adhered to with actions genuinely resulting in resources being deployed to

mitigate any risks to patient safety. Funding arrangements should be retrospective (a mechanism for retrospective agreements can be drawn up in advance) and secondary to patient safety. This isn't the case at the moment.

3. What, in your view, needs to be done to ensure that A&E is used appropriately in the future?

National, local regional communication to patients in advance of, and through, the winter months. Alternatives to A&E for example walk in centres or urgent care centres. In Guildford there are no other access points like this apart from the hospital. Investment in community services to support people remaining in the community. Assessment of need in residential homes for escalation to nursing care to prevent homes using A&E as a place to deal with patients increasing needs.

4. What are the risks to A&E performance in your area?
   Lack of community health and social care capacity to keep people in their own homes: Lack of flexibility in patients able to access community beds: Needs and demand not matched to capacity: Space in the unit needs matching to capacity (underway). Processes for the management of continuing care are cumbersome and result in delays.

5. Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?
   Support all assessments for care outside of the hospital, including CHC.

I hope this information helps with your review of winter and I am more than happy to talk more about this at any time

Kind regards

Paula Head

Paula Head
Chief Executive

Please reply to:
Michael Wilson
Chief Executive Officer
☎: Direct Line 01737 231817
email:michael.wilson@sash.nhs.uk

Trust Headquarters
East Surrey Hospital
Canada Avenue
Redhill
RH1 5RH

Tel: 01737 768511
www.surreyandsussex.nhs.uk

22nd February 2017

Cllr Bill Chapman
Chairman
Wellbeing & Health Scrutiny
Surrey County Council

By Email to: Andrew.spragg@surreycc.gov.uk

Dear Cllr Chapman

Re: Accident & Emergency Performance during Winter Pressures

I am writing in response to your request for our views as to how the Surrey-wide system has responded during to the recent demand of A&E winter pressures. In relation to the specific questions you posed:

1. How did we work with partners in health and social care to manage the increased demand in A&E in December 2017 and January 2017?

Surrey and Sussex Healthcare NHS Trust (SaSH) continues to be a key partner member of the South East Coast (System Resilience Group) which hosts the Urgent Care and Emergency Care Delivery Board. This is the forum where all partners across the health and social care system come together to undertake the assurance of service delivery and performance.

The delivery board has been active throughout the year in planning for the capacity required to ensure delivery, and oversee the co-ordination and integration of services to support the delivery of effective, high quality accessible services. One of the main focuses of this group has been ensuring that all parts of the health and social care system have a robust winter plan. The delivery board also oversees implementation, review and monitoring of the agreed plan.

In addition to the health and social care system-wide plan, SaSH has in place a Winter Plan which has been designed by our senior clinical leadership team. The key components of our plan include:

- Ensuring we have learnt and implemented lessons from previous winter pressures (i.e. 2015/16)
- Continuing improvements from our rolling plan of “Breaking the Cycle” weeks throughout the year
- Taking stock of lessons from operational pressures from the series of junior doctor industrial action days during 2015 and 2016
- Continuing with the integrated reablement unit and identifying patients medical ready for discharge (MRD)
- Implementation of ambulatory care pathways include the new Pendleton Frailty Unit
- Embedding clinical leadership reviews of agreed acute clinical pathways

- Implementation of SAFER patient flow bundle (a standardised way of managing patient flow through hospitals. If consistently followed with minimal variation the bundle will help improve patient flow
- SaSH escalation systems plan and the Single Health Resilience Early Warning Database (online, real-time early warning and decision support tool which is a system designed to be accessed and updated by partners within a local health system in order to share 'system critical' information)

2. What plans are in place in your area to manage such a spike in demand should it re-occur in 2017/18?

- The Delivery Board has adopted the mandated initiatives as outlined by the National Delivery Improvement Plan:
- Streaming at the front door
- Ambulance response programme
- Discharge
- NHS 111

In addition in year 1 of the Sussex and East Surrey Sustainability and Transformation Plan has identified the following priorities:

- New primary and community urgent care models: networked with acute hospitals, aiming to make better use of resources
- Frailty (primary care): led by primary care, develop services for older people that respond to their complex needs;

The STP has also identified that one of the largest opportunities so solve some the challenges faced is to maximise the number of acute beds. The Central Sussex and East Surrey Alliance (CESEA) Plan has also identified improved access to urgent care as a key priority.

Winter planning for 2017/18 will continue to be a high priority nationally and locally. With the background work already undertaken by the system through the STP all organisations should be better place to deliver significant improvements for winter in 2017/18.

3. What, in our view, needs to be done to ensure that A&E is used appropriately in the future?

- Easily recognizable and consistent ‘provision and labelling of non acute urgent care centers across the health system to discourage attendance at ED being the relied upon default.
- Better promotion by the 111 service of alternative centers for minor injuries and non-emergency treatment and advice (e.g. pharmacies)

4. What are the risks to A&E performance in our area?

- Ambulance conveyancing not being centrally coordinated to spread demand after dispatch.
- Delays to discharge that impact on flow and number of acute beds available. This is best managed by an integrated system that incentivizes patient flow and is performance managed at a system wide level rather than by individual providers.

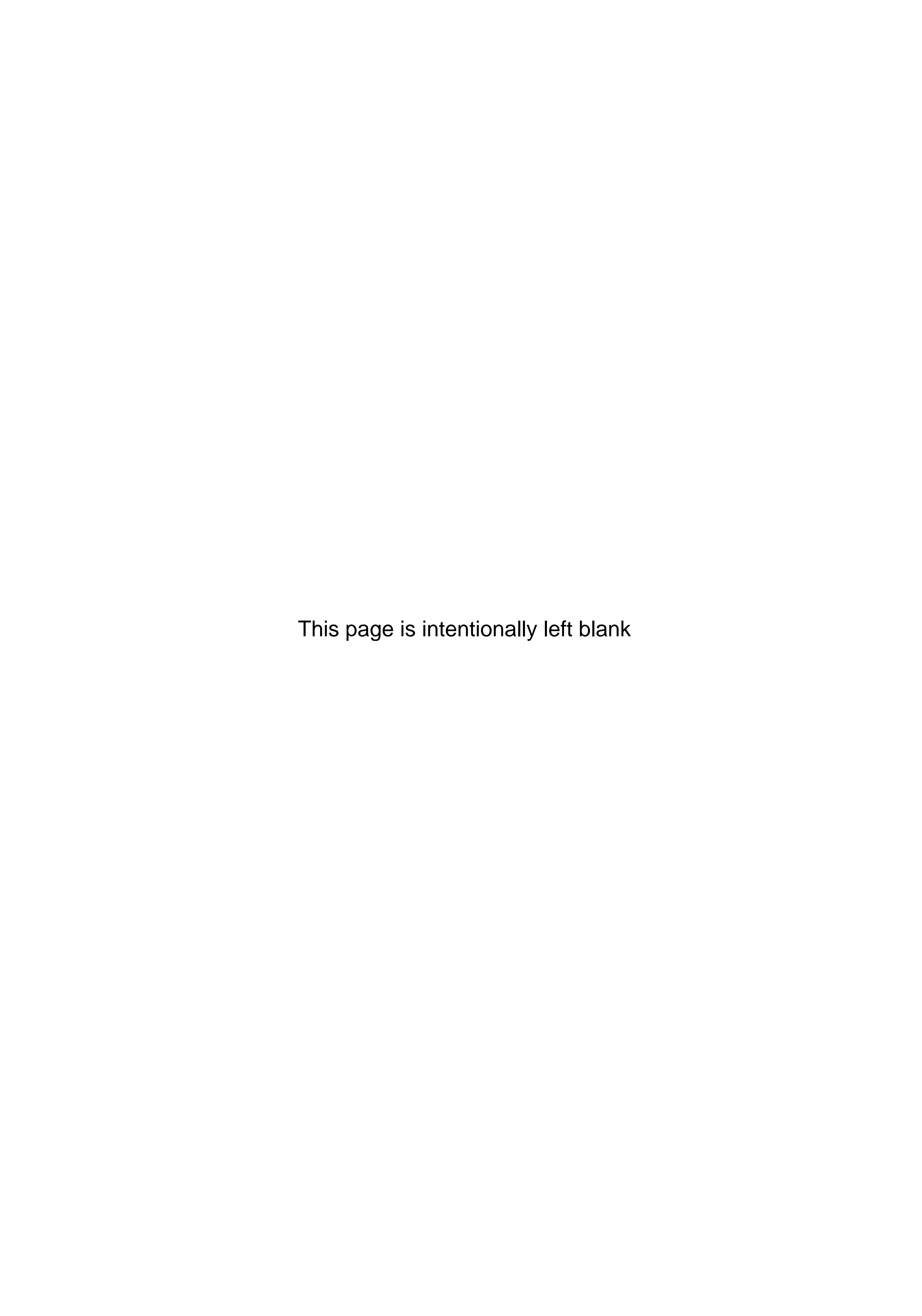
5. Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?
   - Discharge to assess models
   - Key performance indicators should be agreed across the health and social care economy that are consistent rather than in potentially in conflict.
   - Gap analysis should drive provision i.e. more beds and less packages of care

I hope our response is helpful to the deliberations of the Wellbeing and Health Scrutiny Committee.

Thank you for your invitation to attend the Scrutiny Board meeting on 13th March 2017 at 10.30am. Either I or an appropriate member of the Executive Team will be available to attend the meeting and we look forward to being able to discuss with you further and respond to any questions from the Committee.

Kind regards

Michael Wilson CBE
Chief Executive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Annex 2

St Peter's Hospital
Guildford Road
Chertsey
Surrey
KT16 0PZ

DX 119775, Chertsey 2

Tel 01932 872000
Web www.ashfordstpeters.nhs.uk

3rd March 2017

Bill Chapman
Chairman
Wellbeing and Health Scrutiny
Surrey County Council

Dear Councillor Chapman

Further to your letter dated 25th January requesting information on how we are managing Accident and Emergency performance during winter pressures, we have set out below our answers to your individual questions. As you will know, managing A&E performance and its associated impact on other health and care services is a system issue and thus our responses are on behalf of the local health system in North West Surrey.

1) **How did you work with partners in health and social care to manage the increased demand in A&E in December 2016 and January 2017?**

The North West Surrey system has managed well over the winter period so far. Significant planning and preparation was undertaken prior to the winter period, building on the learning from the previous two winters.

In preparation for the winter period the Local A&E Delivery Board (LAEBD), consisting of senior representatives from all system partners and the wider system undertook a number of actions to support going into winter in the best possible position and to ensure resilience. Key actions undertaken were;

- Two LAEDBs dedicated to undertaking exercises to test preparedness resilience. Updates were made to the whole system surge and escalation plan as a result.
- Two 'Ready for Winter' days at the hospital – a whole system, collaborative approach to timely discharge, maximising patient flow and minimising length of stay. The aim of these days was:
  1. To discharge as many medically fit patients as possible within 24 hours
  2. To have a concrete timed discharge plan for the remaining medically fit patients
  3. To identify trends of delays within our services and use this information to help plan the actions required for winter across our system.
- LAEDBs were scheduled weekly throughout December and January.
- Daily system calls were scheduled over weekends and bank holidays proactively over the Christmas/New Year period.

- Chief Executive level Cabinet calls were triggered, as planned, when the system moved to OPEL 3 and continued until de-escalation to OPEL 2.

A number of resilience initiatives were agreed, these included;

- Provision of GPs in nurse-led Walk-in Centres at weekends and bank holidays from 1st December 2016, due to continue until the end of March 2017.
- GP support to community hospital wards at weekends and bank holidays from 1st December 2016 and due to continue until the end of March 2017.
- Provision of a weekend X-ray service at the WICs from 1st December 2016, due to continue until the end of March 2017.
- Extended Rapid Response In-reach to A&E in the evenings and at weekends from 1st December 2016 until the end of March 2017.
- Additional funding for packages of care through Alpenbest (70 hours) and Adecco from mid-December to mid-February.
- Additional on-site management presence at St Peter's Hospital to support patient flow.
- Phased opening of escalation bed capacity.

In addition, a public communication campaign to advise people on where to seek most appropriate care was undertaken and is scheduled to continue throughout the winter period. This has included social media (including two dedicated videos), online advertising, distribution of information on urgent care services, and local paper advertising.

A key difference from last year is the implementation of the Discharge to Assess (D2A) programme which aims to enable patients to be discharged from hospital in a safe and timely way with support from an integrated Health and Social Care Team, without having to wait for longer term support options to become available. As part of this collaborative initiative, the establishment of an Integrated Care Bureau (ICB) has enabled a joint response between the Rapid Response and Adult Social Care Re-ablement services - via the ICB - sharing capacity to meet supported discharge demand.

Overall, strong partnership working and break planning has resulted in a number of areas of improvement on last year and have sustained flow through a period of increased demand. Although not achieving the 95% standard, resilience has been demonstrated. The LAEDB reflected that partnership working this year was improved and had a positive impact on system performance and flow.

2) **What plans are in place in your area to manage such a spike in demand should it re-occur in 2017/18?**

As a system, we will continue to work collaboratively to support A&E recovery and ensure resilience as a system. As an LAEDB we have done an interim review of the Christmas/New Year period to identify any immediate learning and improvements required. A more comprehensive review of the winter period will be undertaken as an LAEDB in due course.

3) **What, in your view, needs to be done to ensure that A&E is used appropriately in the future?**

It is important to ensure that A&E performance is recognised as a whole system issue, and that all areas of the health and social care system contribute to ensuring we keep A&E free for those patients who really need it. To facilitate this, we feel the following would support;

- Increase in national communications around winter pressures, access to urgent care services and self-care information and support.
- National patient education programme or communication to support the public to self-care and to enable them to make the most appropriate decisions in accessing urgent care services.
- Investment in primary care services to facilitate improved access to urgent appointments, providing an alternative to A&E.

4) **What are the risks to A&E performance in your area?**

A&E performance is whole system issue, and therefore wider health and social care system challenges impact on local performance. As a system we face the following challenges;

- Recruitment and retention difficulties within A&E and the wider hospital, therefore reliance on expensive locum and agency staff, make the sustainability of effective processes in A&E a challenge.
- The current A&E environment and infrastructure is not conducive to managing the peaks in attendance at current levels of demand.
- Managing the social care demand within existing funding is extremely challenging, especially when competing with the strong private funder market.
- On-going independent sector market challenges within Surrey – availability of placement and complex packages of care – particularly prominent over the holiday periods.
- Recruitment and retention affecting all providers across North West Surrey, contributory factor is the London weighting available if working for other local providers.
- Change in community services provider from 1st April 2017 (from Virgin Care to CSH Surrey) which will understandably disrupt the system. However, at the same time this also presents a great opportunity to build new relationships and improved pathways for our patients.

5) **Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?**

There has been strong partnership working and engagement from all system partners, with social care and community providers contributing significantly to the management of the winter pressures experienced and the recovery efforts.

Annex 2

I trust this response will give the Committee a good understanding of the pressures facing the North West Surrey system and the progress we are making; in the meantime, we look forward to discussing this in more detail on 13th March.

Yours sincerely

Suzanne Rankin

Chief Executive

Wellbeing and Health Scrutiny Board
13 March 2017

Integrated Sexual Health Services

Purpose of the report: Scrutiny of services

The Board has requested an update on the mobilisation of the integrated sexual health services contract from 1 April 2017. This follows a decision by the Council's Cabinet to award the contract to Central and North West London NHS Trust in September 2016.

Background

1. On 20 September 2016[1] the Cabinet made the following decision:

   APPROVAL TO AWARD A CONTRACT FOR THE PROVISION OF AN INTEGRATED SEXUAL HEALTH SERVICE (Item 6)

   RESOLVED:

   - *That a contract be awarded to Central and North West London NHS Trust at a maximum value of £4,333,383.00 per year.*

   - *The contract will be for three years from 1 April 2017 with an option to extend for a further two years, in any event the contract shall be for no more than five years in total.*

   Reasons for Decisions:

   The recommended contract award will deliver an evidence based Integrated Sexual Health Service (as described in paragraph 5 of this report) that meets national guidance and fulfils the Council's duties. The service will be open access to all (universal) in line with statutory requirements and the national specification issued by the Department of Health, however there is a clear expectation that the service will be responsive to the needs of key priority groups as defined in the Surrey Sexual Health Needs Assessment. Priority groups in Surrey include

[1] Cabinet, 20 September 2016
https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=120&MId=4591&Ver=4
(accessed 1 March 2017)

sex workers, men who have sex with men (MSM), Black Africans and young people.

The three existing contracts for sexual health services are expiring at the end of March 2017 and cannot be further extended.

A full tender process, in compliance with the requirements of EU procurement Legislation and the Council's Procurement Standing Orders has been completed, and the recommendation provides best value for money for the Council following a thorough evaluation process.

The service will be delivered in Surrey from local bases and will provide apprenticeship opportunities to Surrey Young People whilst delivering efficiencies for Public Health Services.

2. The Wellbeing and Health Board Chairman was briefed prior to this decision, and a short update was given as part of his Chairman's report in September 2016[2]. The report highlighted that it had been agreed to receive an update to the full Board six months from the contract mobilisation date (September 2017).

3. The Board has subsequently requested an update in response to concerns raised during contract mobilisation. The Cabinet papers related to this decisions are attached as **annex 1**.

Recommendations:

The Board are asked to note the contents of the report and consider what additional recommendations it would wish to make. It is also recommended:

- that a further update is brought six months from the mobilisation of the new integrated sexual health services contract

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Report contact: Andrew Spragg, Scrutiny Officer, Democratic Services
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Annex 1 – Cabinet paper, 'Approval to Award a Contract for the Provision of an Integrated Sexual Health Service' 20 September 2016

[2] Wellbeing and Health Scrutiny Board, 16 September 2016, 'Chairman's Report' https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=433&MId=4834&Ver=4 (accessed 1 March 2017)

SURREY COUNTY COUNCIL

CABINET

SURREY
COUNTY COUNCIL

DATE: **20 SEPTEMBER 2016**

REPORT OF: **MRS HELYN CLACK, CABINET MEMBER FOR WELLBEING AND HEALTH**

LEAD OFFICER: **HELEN ATKINSON, STRATEGIC DIRECTOR ADULT SOCIAL CARE AND PUBLIC HEALTH**

SUBJECT: **APPROVAL TO AWARD A CONTRACT FOR THE PROVISION OF AN INTEGRATED SEXUAL HEALTH SERVICE**

SUMMARY OF ISSUE:

The provision of sexual health services is a statutory duty of Local Authorities. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 require Local Authorities to arrange for the provision of open access sexual health services including sexually transmitted diseases testing and treatment and free contraception.

The provision of effective sexual health services has an active role in supporting the Council's Corporate Strategy, and in particular the strategic goals of 'Wellbeing' and 'Resident's Experience' as well as delivering against the Council's nine priorities with a particular contribution being made to "keeping families healthy". Effective sexual health services have a positive effect on the health and wellbeing of Surrey residents and can prevent the need for more intensive and costly interventions from health, social care and the wider public service sector.

The budget for this service has been reduced following the reduction in the ring fenced public health grant distributed by the Department of Health. The Council is trying to maintain a good level of service within the financial resource available.

Following a full procurement and evaluation process, this Cabinet report seeks approval to award a contract to Central and North West London NHS Trust for the provision of an Integrated Sexual Health Service to commence on 1 April 2017. The recommended contract delivers best value for money and meets the needs of service users in Surrey. In awarding this contract the Council will secure a cashable saving of £2m per year.

Due to the commercial sensitivity involved in the contract award process, the scoring summary and value for money details have been circulated as a Part 2 report.

The Council has collaborated with NHS England (South East) Area Team (NHSE) to lead a joint procurement which incorporates HIV Treatment and Care and Sexual Health services in prisons for which NHSE are the responsible commissioner. The Council and NHSE will each award a separate contract for their own elements of service and following their own governance processes. This report relates solely to the Council's contract.

RECOMMENDATIONS:

It is recommended that a contract is awarded to Central and North West London NHS Trust at a maximum value of £4,333,383.00 per year.

The contract will be for three years from 1 April 2017 with an option to extend for a further two years, in any event the contract shall be for no more than five years in total.

REASON FOR RECOMMENDATIONS:

The recommended contract award will deliver an evidence based Integrated Sexual Health Service (as described in paragraph 5 of this report) that meets national guidance and fulfils the Council's duties. The service will be open access to all (universal) in line with statutory requirements and the national specification issued by the Department of Health, however there is a clear expectation that the service will be responsive to the needs of key priority groups as defined in the Surrey Sexual Health Needs Assessment. Priority groups in Surrey include sex workers, men who have sex with men (MSM), Black Africans and young people.

The three existing contracts for sexual health services are expiring at the end of March 2017 and cannot be further extended.

A full tender process, in compliance with the requirements of EU procurement Legislation and the Council's Procurement Standing Orders has been completed, and the recommendation provides best value for money for the Council following a thorough evaluation process.

The service will be delivered in Surrey from local bases and will provide apprenticeship opportunities to Surrey Young People whilst delivering efficiencies for Public Health Services.

DETAILS:

Business Case

1. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 require Local Authorities to arrange for the provision of certain services including:

   - open access sexual health services available to everyone covering Sexually Transmitted Infections (STI) testing and treatment, notification of sexual partner of infected persons and:

   - free contraception and reasonable access to all methods of contraception.

2. It is important that appropriate contractual arrangements are put in place locally to cover such services, to ensure compliance with national clinical guidance, to minimise risk and to ensure value for money. The nature of sexual health services is such that, should appropriate services not be available in Surrey, a larger number of residents will access services in neighbouring authority areas. The Council will still be required to pay for the provision of these services but will have limited influence on the quality or cost.

3. This procurement is underpinned by a detailed sexual health needs assessment. The Surrey sexual health needs assessment particularly identified that:

    - In 2014 the Office of National Statistics (ONS) reported that there were 287 under 18 conceptions (rate of 14.2 per 1,000) with around a third of those resulting in a live birth. Outcomes, in terms of health and wellbeing are reduced for young mothers and their children.

    - This equates to 64.8% of under 18 conceptions in Surrey resulting in termination which indicates that these conceptions were unplanned and unwanted.

    - Runnymede and Spelthorne boroughs have historically shown higher than the national average rates of teenage conceptions (19.7 per 1,000 and 20.3 per 1,000 respectively in 2014). Preston ward within Reigate and Banstead has the highest rate in Surrey.

    - Woking has a higher than national rate of HIV. This has financial implications for both health and social care.

    - Chlamydia detection rates in 15-24 year olds are low (1296 per 100,000 in 2014) which increases the risk of onward transmission, untreated disease and the associated health issues.

4. In addition to offering the universal service, a key ambition is to address some of the inequalities and issues identified in paragraph 3. For example, targeted outreach that focuses on young people to reduce the countywide variation in unplanned conceptions that impact not only on health outcomes but also social care and education. A focus on HIV prevention to reduce late diagnosis of HIV will also result in reductions in costs to the NHS and the need for social care, and a focus on cross partnership working with substance misuse providers to reduce risk taking behaviours.

Background

5. The Council has chosen to procure an integrated sexual health service with a lead provider using a 'hub and spoke' model, as evidence shows us that this is the most effective model. This model will combine the services currently provided under three separate contracts into one countywide service. The hubs will be centrally located and offer a full range of services whilst the spokes would offer generic services such as basic STI testing and condom distribution. The 'hub and spoke' model is used and endorsed nationally and broadly the objectives of the model are to:

    - ensure a service user is able to access a range of services at one location, in one appointment and usually with one healthcare professional

    - offer extended opening hours at accessible locations

    - offer an effective outreach service to 'at risk' groups to ensure targeted and appropriate prevention strategies are in place

    - ensure equitable service delivery across the county

- ensure care pathways are clearly defined and that service users experience quality interventions and seamless care provision

6. The provider will be required to work in partnership with GPs and pharmacies who also provide sexual health services as part of the wider treatment pathway. The provider will be required to develop links with secondary schools, colleges and other health and social care services in order to reach priority groups. The service will target young people via schools and colleges working alongside the Healthy Schools programme. The service will be required to work proactively with other services who engage with people aged 13 to 15 and in particular will provide support to deliver sex education in collaboration with Public Health, school nursing services and the Council's services for young people. The provider will support best practice within the school nursing service to enable the delivery of sexual health services and good relationships and sex education (RSE) in line with government guidance.

Procurement Strategy and options considered

7. Several options were considered when completing the Strategic Procurement Plan prior to commencing the procurement activity. These were to procure the individual elements of service separately, to procure an integrated sexual health service on behalf of SCC with a lead provider and to procure an integrated sexual health service on behalf of both the Council and NHS England (South East) Area Team (NHSE) with a lead provider.

8. After a full and detailed options analysis it was decided that commissioning a specialist integrated sexual health service on behalf of the Council and NHSE was the preferred option as this demonstrated best value for money from the options appraisal completed. A small number of expert providers exist in the market who could be commissioned to deliver the desired outcomes in relation to quality and activity and tenders were invited.

9. A project team was set up which included representatives from Public Health, NHSE, Legal Services, Finance and Procurement.

10. A Concept Day was held in December 2015 for interested stakeholders and attendees included representatives from provider organisations, Clinical Commissioning Groups (CCGs) and Public Health England. Views were sought on the potential commissioning models and specification and these were incorporated as appropriate into the options analysis and decision making process.

11. A full tender process, compliant with EU Public Contract Regulations and the Council's Procurement Standing Orders, has been carried out and this included advertising the contract opportunity in the Official Journal of the European Union.

Key Implications

12. By awarding a contract to Central and North West London NHS Trust for the provision of the Integrated Sexual Health Service, the Council will be meeting one of its duties in improving and maintaining the health and wellbeing of people in Surrey whilst ensuring that it secures best value for money for the service.

13. The staff employed by the current service providers will be offered the opportunity to transfer to the new provider under TUPE regulations. This will help to retain local knowledge and the local skill base whilst the service is redesigned to improve outcomes and deliver value for money.

14. The majority of service will be commissioned using the Integrated Sexual Health Tariff. The tariff enables services to be commissioned using a menu of agreed prices ensuring that the unit price paid reflects the complexity of the intervention. The tariff prices include all costs (clinical staff costs, on costs, cost of significant equipment and overheads). Adopting tariff based pricing enables the commissioner to pay for service actually delivered rather than the traditional block contract method with its associated void cost.

15. In addition the contract will include a small block contracted element of service for targeted outreach.

16. The contract will have a greater focus on prevention and innovation which will mean a shift from the traditional model of face-to-face consultations to a model where online booking, online triage and self sampling (where service users are sent testing kits in the post and return a sample to the provider for testing) become more prominent. This will allow consultant time to be carefully managed and targeted to focus more on acute care with dual trained nurses (trained to deliver both contraception services and genito-urinary medicine) providing a significant element of the general care. This move to a more modern and efficient model of service delivery is in line with changes being made nationally by other local authorities and will enable the Council to continue to deliver services within a reduced budget envelope.

17. The three main national Public Health Outcomes Framework (PHOF) outcomes associated with sexual health are:

    - Under 18 conceptions – the measure is the rate of conceptions per 1000 of the under 18 population

    - Chlamydia diagnoses – this is measured by the amount of Chlamydia infections detected in the 15-24 year old population. The rate should be 2300 per 100,000

    - People presenting with HIV at a late stage of infection

18. Performance will be monitored through a series of Key Performance Indicators (KPIs) as detailed in the specification and reviewed at quarterly meetings. A number of KPIs are set nationally by the Department of Health (DoH) and these are in line with the PHOF, others are set locally to reflect local priorities as determined by the needs assessment.

Three of the KPIs are illustrated in the table below out of a total of 46.

KPI	Target	Notes
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment	100%	British Association for Sexual Health and HIV (BASHH Standard 1)

undertaken.		
The ratio of all contacts of Chlamydia index case whose attendance at a Level 1, 2, or 3 sexual health service was documented as verified by a Health Care Worker, within four weeks of first Partner Notification discussion	At least 0.4 contacts per index case for all clinics (in and outside London) and documented within four weeks of date of first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections National Chlamydia Screening Programme Standard 4
Documented evidence within clinical records that Partner Notification has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk	90%	British HIV Association (BHIVA) Standard 7[1]

The management responsibility for the contract lies with Public Health and the contract will be managed in line with the contract management plan as laid out in the contract documentation and the Council's Supplier Relationship Management principles. Performance will also be robustly monitored locally at quarterly contract meetings. In addition, sexual health services are monitored by two national datasets. GUMCAD (Genitourinary medicine activity dataset) is the dataset for STI testing and treatment and SHRAD (Sexual health and reproductive activity dataset) is the dataset for contraception. All services are required to report into these systems.

Competitive Tendering Process

19. The contract has been let as a competitive tendering exercise. It was decided that the open procedure was appropriate and bidders were given 45 days to complete and submit their tender. One tender was received from a large, established provider of healthcare services (including sexual health) and they were evaluated against both cost and quality criteria and weightings, the results being that Central and North West London NHS Trust achieved a total score of 61.33%. A full score summary is provided in the Part 2 report.

20. This is the first time that a clinical service, which is commissioned to NHS guidelines has been procured by the Council. The tender evaluation panel included representatives from Public Health, NHSE, Children Schools and Families, a consultant representative and a GP and pharmacy representative. In addition a panel of two young people took part in the evaluation process.

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[1] British HIV Association (2013). *Standards of Care for People Living with HIV* http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf

CONSULTATION:

21. Commissioners from Public Health, Children, Schools and Families, colleagues from Finance, Legal Services and Procurement have been involved and consulted throughout the process.

22. Relevant external stakeholders were consulted at various stages in the process at both the Concept Day (see paragraph 10 above) and at the market engagement event for providers held on 27 April 2016 prior to the issue of the tender.

23. The Local Pharmaceutical Committee and the Local Medical Committee have been informed and have had the opportunity to comment. Representatives from each committee attended the Concept day, Market Engagement Event and/or received all relevant documentation.

RISK MANAGEMENT AND IMPLICATIONS:

24. The contract includes relevant termination clauses including a termination for convenience clause which will allow the Council to terminate the contract with 6 months notice should priorities change. In addition, immediate termination is possible if the service provider commits a breach of the terms of contract or the provider at the time of the contract award, has committed an offence under the Public Contract Regulations 2015.

25. The short listed bidder successfully completed the standard financial checks.

26. The following key risks associated with the contract and contract award have been identified, along with mitigating activities:

Category	Risk Description	Mitigation Activity
Financial	The budget allocated may be insufficient should volumes of activity increase significantly or should the service redesign take longer than envisaged	The Council and the provider will work in partnership to manage demand and any seasonal variation. The provider will be flexible and have the ability to alter clinic times to ensure any 'dead' time is removed from the system. The provider will ensure staff time is used appropriately e.g. consultant time is used only where necessary. The provider and Council will work closely with GPs and Pharmacies and will cross refer service users as appropriate to primary care provision to ensure efficiency across the whole system.
	Further cuts to the Public Health budget	The Council and the provider will work together to manage any future cuts and minimise the impact on both volumes and the quality of service delivery.

Reputational	The move to a fully integrated service requires significant service redesign which will impact staff and service users	The Council and provider will work together throughout the mobilisation period and into the life of the contract to ensure such changes are managed sensitively and effectively. Appropriate consultations will take place and a communication plan (both internal and external) will be set out.
Service Delivery	Quality of service delivered does not meet objectives and needs.	Strong contract management and quarterly contract review meetings. Detailed mobilisation period with sufficient time (6 months allocated).

Financial and Value for Money Implications

27. Further details of the value for money and financial implications are set out in the Part 2 report.

28. The procurement activity will deliver a service within budget and will generate a saving of £2m per year which will contribute to savings required within the Medium Term Financial Plan (MTFP) for Public Health.

29. In addition the following Value for Money implications should be noted:

- The outreach element of service will focus on prevention work and behaviour change to increase healthy sexual behaviour and reduce the need for clinical services. The ambition is to reduce the countywide variation in unplanned conceptions for young parents that can impact not only health outcomes but also social care. Within the Family Nurse Partnership trial it was identified that almost 60% of children involved in serious case reviews were born to mothers under 21.

- The contract will include HIV prevention and aim to reduce late diagnosis of HIV which will reduce costs to the NHS as well as reduce the need for social care and the associated costs for the Local Authority.

30. It is recognised nationally that spending money on sexual health services can save significant amounts of money further down the line to both health and non health (including local authority) services. The report 'Unprotected Nation 2015' commissioned by the Family Planning Association shows the potential impacts of a reduction in access to services. It illustrates that:

- nationally a 10% reduction in access could result in the total cost of unintended pregnancies and STIs increasing from £69.092 billion to as much as £77.750 billion over the period 2015 – 2020. A significant portion of this increase (circa £7.2 billion) would relate to non heath costs such as social welfare, housing and education.

- nationally reductions to the public health ring fenced grant already announced become the norm over the next five years, nationally every £1 of expenditure cut could cost as much as £86 further down the line.

- nationally a 10% reduction scenario could cause an extra 72,299 STIs by 2020, this equates to a cost of £363 million and includes 20,000 additional gonorrhoea cases, at a time when we are seeing the emergence of antibiotic-resistant strains of the infection

31. The model selected for this procurement aims to minimise these impacts through the move to more innovative service delivery. Indeed, the bidder has confirmed within their tender submission that they would be able to service the current volumes albeit through the greater use of self sampling, more targeted appointments and clinic times and appropriate use of staff skill mix.

Section 151 Officer Commentary

32. The S151 Officer is supportive of the bid as it moves the service financially into a more cost efficient position, which is a priority to meet cost savings within this budget area. This integrated service uses some new ways of working to achieve a more efficient model of delivery and achieve savings, whilst delivering all the services required. This work will be monitored to ensure delivery continues successfully.

Legal Implications – Monitoring Officer

33. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, National Health Service Act 2006, and Local Government and Public Involvement in Health Act 2007 require local authorities to arrange for the provision of sexual health services.

34. The procurement process was undertaken in accordance with procurement legislation and the Council's own internal procedures as outlined in the constitution.

Equalities and Diversity

35. Under section 149 of the Equality Act 2010, Cabinet must comply with the public sector equality duty, which requires it to have due regard to:

    a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act,

    b. advance equality of opportunity between persons who share a relevant characteristic and persons who do not share it,

    c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

36. An Equalities Impact Assessment has been written and is attached as Annex 1. It sets out the impacts of the recommendation on each of the protected group for each service. A range of positive impacts have been identified for some groups.

Safeguarding responsibilities for vulnerable children and adults implications

37. The terms and conditions of contract stipulate that the provider will comply with the Council's Safeguarding Adults and Children's Multi-Agency procedures, any legislative requirements, guidelines and good practice as recommended by the

Council. This will be monitored and measured through the contractual arrangements.

38. The service will operate a client centred approach, working collaboratively with other Health and Social Care Services.

Public Health implications

39. The specification stipulates that the provider will develop links and referral mechanisms into other health improvement programmes such as services for young people – particularly Youth Support Service, early help, substance misuse services (including alcohol) and smoking cessation.

WHAT HAPPENS NEXT:

40. The timetable for implementation is as follows:

Action	Date
Cabinet decision to award (including ‘call in’ period)	27 September 2016
Contract Signature	28 September 2016 – 1 March 2017
Contract Commencement Date	1 April 2017

41. Ordinarily the Council has an obligation to allow unsuccessful bidders the opportunity to challenge the proposed contract award by observing an ‘Alcatel’ standstill period. Legal advice in this case is that the Alcatel period does not need to be observed as only one bid was received.

42. The Council will work closely with the new provider and the current providers to ensure a smooth transfer of services. The new provider will be required to put in place a full mobilisation plan and co-ordinate the process.

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Lisa Andrews, Senior Public Health Lead Tel: 01483 519634

Consulted:
Anna Tobiasz, Category Manager (Procurement)
Laura Langstaff, Head of Procurement
Christine Danquah, Paralegal
Carmel McLoughlin, Principal Solicitor
Ruth Hutchinson, Deputy Director of Public Health
Lucinda Derry, Principal Accountant
Sian Ferrison, Transformation and Development Manager (Finance)
Cllr Peter Martin, Deputy Leader of the Council

Annexes:
Equality Impact Assessment

Sources/background papers: None

Equality Impact Assessment Template

1. Topic of assessment

EIA title:	Re-commissioning of sexual health services

EIA author:	Lisa Andrews

2. Approval

	Name	Date approved
Approved by[1]	Helen Atkinson	26/08/2016

3. Quality control

Version number	3	EIA completed	30/08/2016
Date saved	25/08/2016	EIA published	

4. EIA team

Name	Job title (if applicable)	Organisation	Role
Lisa Andrews	Senior Public Health Lead	SCC	
Hannah Bishop	Public Health Lead	SCC	
Luke Burton	Policy & Strategic Partnerships Manager	SCC	

5. Explaining the matter being assessed

What policy, function or service is being introduced or reviewed?	This Equality Impact Assessment relates to the provision of sexual health services in Surrey. Sexual health prevention services are funded wholly by the public health grant. Sexual health is an important and wide-ranging area of public health. Most of the adult population of England are sexually active, and having the correct sexual health interventions and services can have a positive effect on long-term health and wellbeing, as well as on individuals at risk. The provision of sexual health services is a statutory duty of Local Authorities. The provision of effective sexual health services has an active role in supporting the Council's Corporate Strategy and in particular the Strategic Goals of 'Wellbeing' and 'Resident's experience' as well as delivering against the council's nine priorities with a particular contribution being made to "keeping families healthy".

[1] Refer to earlier guidance for details on getting approval for your EIA.

	Surrey's vision for sexual health services • An integrated service aiming to offer a one-stop-shop for service users • A service which has links with other services addressing risky behaviours, particularly in younger people examples include youth support service and Catch 22 • A service which is focussed on improving sexual health, reducing STIs and unintended conceptions; building self-reliance and resilience • A cost effective and modern service meeting the needs and expectations of users, making full use of developing technologies • Targeted universalism that will ensure services for all with additional support for those at risk of poorer sexual health In 2015 public health completed a sexual health needs assessment for Surrey. Key messages from Surrey's Sexual Health Needs Assessment: • Runnymede and Spelthorne boroughs have historically shown higher than the national average rates of teenage conceptions. Preston ward within Reigate and Banstead has the highest rate in Surrey. Guildford borough has the highest number of young people • Over 60% of teenage conceptions result in termination. • Woking has a higher than the national rate of HIV • Chlamydia detection rates in 15-24 year olds are low (1296/100,000 in 2014) • Consideration needed for the geography of Surrey • Through engagement work it was identified that both adults and young people wanted better access to services, this included more flexible opening times such as evenings and weekends • Both adults and young people felt that sexual health services could be promoted more effectively • Services could be better promoted online i.e. through the Healthy Surrey website • Surrey County Council Public Health must look for opportunities and work with our commissioning colleagues in CCGs and NHS England to ensure pathways are joined up in order to improve patient experience and health outcomes • Variations in service provision across the county needs to be addressed during the re-commissioning of services. This will ensure resources are more effectively targeted to meet needs • Integration of services would allow needs to be met

	holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience As sexual health services are open access there are around 15,000 attendances by Surrey residents to out of area (OOA) services. Around 50% of out of area attendances are made to bordering counties or London Boroughs. Lack of appropriate provision within Surrey could see a rise in out of area attendances . The full Sexual Health Needs Assessment is available here: https://www.surreyi.gov.uk/Resource.aspx?ResourceID=1678&cookieCheck=true.
What proposals are you assessing?	This EIA is assessing the introduction of a new provider of sexual health services in Surrey from April 2017. Current service contracts end on 31 March 2017. Following engagement with current and potential service providers and staff at a Concept Day in December 2015 and Market Engagement Event in April 2016, in May we went out to tender for an integrated sexual health service using a lead provider model. This service includes Contraception and Sexual Health (CASH) and Genito-urinary Medicine (GUM) clinical services as well as an outreach offer for those groups identified as most at risk in the sexual health needs assessment, young people, men who have sex with men (MSM), black Africans and sex workers. This re-procurement consolidates the three main existing providers of sexual health services in Surrey; • Virgin Care, • Ashford and St Peter's Hospital (ASPH) and • Frimley Park Hospital (FPH). After the restricted tender process we received one bid from Central and North West London. This integrated service will use some new ways of working to achieve a more efficient mode of delivery and achieve savings, whilst delivering all services required. We will work with the provider to ensure that staff have had the necessary training in order to support service users with protected characteristics, such as Trans Awareness and cultural sensitivity training.
Who is affected by the proposals outlined above?	Sexual health services are open access for the whole population. The new service will be a universal service with targeted activity to increase access for at risk groups such as Men who have sex with Men, young people, Sex Workers and Black Africans.

6. Sources of information

Engagement carried out
• Discussion around contract negotiations with Virgin, ASPH and FPH • Engagement activities carried out as part of the re-procurement process for the Integrated Sexual Health Service • Sexual Health Needs assessment included focus groups with young people and surveys with health professionals and service users
Data used
• Sexual Health Services Concept Day • Sexual Health Services Market Engagement Event • User feedback through contract monitoring • Sexual health needs assessment

Equality Impact Assessment Template

7. Impact of the new/amended policy, service or function
7a. Impact of the proposals on residents and service users with protected characteristics

Protected characteristic[2]	Potential positive impacts	Potential negative impacts	Evidence
Age	All age groups are welcome to access the service should they need it for their contraception or STI screening needs. Under 25s typically don't access clinical services compared with those aged over 25, as such they will be targeted by the outreach service. The outreach element of the service will ensure that safer sex messages are being communicated to younger age groups (16 – 24 year olds) particularly those who engage in risky sexual behaviour. The service specification details that this service must work with and align to services for young people to minimise harm and increase access. Integration of services allows needs to be met holistically.		The most at risk and vulnerable young people in Surrey do not engage well with existing services

[2] More information on the definitions of these groups can be found here.

Equality Impact Assessment Template

	Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.		
Disability	This information is currently not being collected. The tender specifications includes a requirement that this information is captured and reported. This will help the commissioners to monitor use of the service by disabled people. Accessible Information Standard: By **1 April 2016** all organisations that provide NHS or publicly funded adult social care must identify and record information and communication needs with service users: • At the first interaction or registration with their service • As part of on-going routine interaction with the service by existing	Potential barriers to access are physical accessibility and communication with people with sensory impairments and learning disabilities. The tender will require all potential providers to provide evidence that they can address accessibility issues. .	

	service users. Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.		
Gender reassignment	Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.		
Pregnancy and maternity	Public Health commissioned sexual health services are key providers of contraception to girls and women in Surrey. Integration of services allows needs to be met holistically. Dual trained clinicians would		It is widely understood that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. There is also a growing recognition that socio-economic disadvantage can be both a cause and a consequence of teenage motherhood. Teenage pregnancy rates are a well established and evidence based indicator of deprivation and inequality with 50% of all teenage conceptions occurring in the top 20%

Equality Impact Assessment Template

	mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing. Sexual health services provided during pregnancy such as Chlamydia screening will continue to be provided by maternity. Existing links to maternity and GPs will be maintained		most deprived wards in England. Poor self-esteem, lack of aspiration and alcohol misuse increase the likelihood of a teenage girl falling pregnant. The babies of teenage mothers can face more health problems such as premature birth or low birth weight and higher rates of infant mortality; than those of older mothers. Teenage mothers themselves may also have experience health problems. For example, post natal depression is three times more common in teenage mothers; smoking in pregnancy is also three times more common in teenage mothers than older mothers and teenage mothers are one third less likely to breast feed.
Race	The service specification requires the provider to work with groups most at risk of sexual ill health. In Surrey the Black African population at risk of HIV will be targeted by the service. The service specification includes outcome measures for at-risk groups. Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians,		Based on data from England and Wales, HIV prevalence in the UK was 26 per 1,000 among black African men and 51 per 1,000 among black-African women. Over the past five years, an estimated 1,000 black-African men and women probably acquired HIV in the UK annually. Approximately half (52%, 1,560/2,990 in 2011) of all infections among heterosexuals were probably acquired in the UK. This proportion has increased over recent years, up from 27%.

	improving patient access and experience. There will be increased access to online testing.		
Religion and belief	The outreach service will ensure that communities at risk who are part of faith groups are engaged. Links with HIV providers and developing relationships will allow fact based inclusive information to be delivered in a sensitive way to encourage community figures to deliver safer sex messages. Services are open access and will be offered on days and times to suit service users) Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.	Targeting of faith groups in relation to sexual health may not be well received by some communities.	

Equality Impact Assessment Template

Sex	Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.	Young men are less likely to access contraception services in the community or GPs	http://www.sexeducationforum.org.uk/evidence/data-statistics.aspx#Use of sexual health services
Sexual orientation	Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing. MSM will be targeted by the service as an at-risk group.	Lesbian, Gay and Bisexual people may experience Sexual health fatigue as they are a group heavily targeted.	MSM (men who have sex with men) remain the group most affected by HIV with 47 per 1,000 living with the infection. This is equivalent to an estimated 41,000 (37,300-46,000) MSM living with HIV in 2012, of whom 7,300 (18%; 3,700-12,300) were unaware of their infection (18%).
Marriage and civil partnerships	Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience.		

	Partner notification of positive STI test results will continue to be offered by the service allowing service users to remain anonymous if they choose to. There will be increased access to online testing.		
Carers[3]	Integration of services allows needs to be met holistically. Dual trained clinicians would mean GUM and CASH services could be delivered by the same clinicians, improving patient access and experience. There will be increased access to online testing.		

[3] Carers are not a protected characteristic under the Public Sector Equality Duty, however we need to consider the potential impact on this group to ensure that there is no associative discrimination (i.e. discrimination against them because they are associated with people with protected characteristics). The definition of carers developed by Carers UK is that 'carers look after family; partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. This includes adults looking after other adults, parent carers looking after disabled children and young carers under 18 years of age.'

8. Amendments to the proposals

Change	Reason for change

9. Action plan

Potential impact (positive or negative)	Action needed to maximise positive impact or mitigate negative impact	By when	Owner
All age groups are welcome to access the service should they need it for their contraception or STI screening needs. The outreach element of the service will ensure that safer sex messages are being communicated to younger age groups (16 – 24 year olds) particularly those who engage in risky sexual behaviour.	The service specification details that this service must work with and align to services for young people to minimise harm and increase access	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL
Data on disability is not currently being collected. The tender specifications will include a requirement that this information is captured and reported. This will help the commissioners to monitor use of the service by disabled people.	Implementation of AIS Accessible Information Standard: By **1 April 2016** all organisations that provide NHS or publicly funded adult social care must identify and record information and communication needs with service users: • At the first interaction or registration with their service • As part of on-going routine interaction with the service by existing service users.	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL

Potential barriers to access are physical accessibility and communication with people with sensory impairments and learning disabilities.	The tender will require all potential providers to provide evidence that they can address accessibility issues and provide accessible communications The contract stipulates that services must be compliant with the Equality Act 2010.	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL
Targeting of faith groups in relation to sexual health may not be well received by some communities.	Develop a fully inclusive engagement plan to get sexual health messages to different population groups taking into consideration different faiths and cultures.	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL
Young men are less likely to access contraception services in the community or GPs	Engagement with young men through services for young people and outreach arm of service	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL
MSM may experience Sexual health fatigue as they are a group heavily targeted.	Engagement with MSM through service mobilisation and outreach arm of service	Through mobilisation and by Q3 of new service	Lisa Andrews and CNWL

10. Potential negative impacts that cannot be mitigated

Potential negative impact	Protected characteristic(s) that could be affected

11. Summary of key impacts and actions

Information and engagement underpinning equalities analysis	• Focus groups and surveys with service users and health professionals • Stakeholder engagement events prior to going out to tender (Concept day and Market Engagement Event) • Sexual Health Needs Assessment for Survey (published February 2016) • Discussions with current contract holders • Multi-agency project group leading on recommissioning process within Surrey County Council

Key impacts (positive and/or negative) on people with protected characteristics	• Services are universal access i.e. for all ages; • Improving data collection on disability • DDA Compliance and accessibility of new service; • Young men less likely to access contraception services in the community and GPs; • Fatigue of groups regularly targeted with sexual health messages i.e. MSM.
Changes you have made to the proposal as a result of the EIA	Identified key actions to take place during the mobilisation period
Key mitigating actions planned to address any outstanding negative impacts	Maintain oversight of the implementation of the service specification and of service development to ensure identified actions are carried out including; • Align to and engage with services for young people; • Reviewing DDA compliance; • Approach of outreach service targeting at-risk groups including young people, young men and MSM.
Potential negative impacts that cannot be mitigated	None