



## Health, Integration and Commissioning Select Committee

4 July 2018

### Sexual Health Services Task Group Final Report

#### Purpose of report:

To provide the Select Committee with a detailed report on the findings of the Sexual Health Service Task Group's review into communication and engagement conducted by Surrey County Council and NHS England commissioners during the development and implementation of an integrated Sexual Health and HIV Service for Surrey.

#### Acknowledgements:

Perhaps the most striking aspect of the review process was the willingness of those involved in or impacted by the introduction of the Integrated Sexual Health and HIV Service to contribute to the Task Group's review. From those who commissioned the Integrated Service right through to patients and potential patients, candour has been a clear and consistent feature of the evidence heard by the Task Group throughout its review.

Members of the Sexual Health Services Task Group would like to formally thank all those who contributed to the review and anticipate that the outcomes from this report will provide sufficient compensation to the many people who have been so generous with their time.

Any errors, factual inaccuracies or inconsistencies contained within the report are the responsibility of the Sexual Health Services Task Group alone and not of those who contributed their knowledge, insight and experiences to the formation of this report.

#### Introduction:

#### The Context

1. In 2013, the Department of Health published a National Service Specification for Integrated Sexual Health Services. It was produced to support local authorities in delivering on the Government's aspiration to improve the sexual health of the population by helping councils commission 'effective, high quality, integrated sexual health care'.<sup>1</sup> Guidance produced by Public Health England entitled 'Making it Work: A Guide to Whole Systems Commissioning for Sexual Health, Reproductive Health and HIV'<sup>2</sup> highlights the importance of councils working in close collaboration with

<sup>1</sup> Department of Health (2013). *Integrated Sexual Health Services: National Service Specification*. ([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/210726/Service\\_Specification\\_with\\_covering\\_note.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf)) as accessed on 26 June 2018

<sup>2</sup> Public Health England (2015). *Making it Work: A Guide to Whole Systems Commissioning for Sexual Health, Reproductive Health and HIV*.

NHS England and Clinical Commissioning Groups (CCGs) in establishing integrated sexual health services. This Guidance outlines some of the advantages of local authorities, Clinical Commissioning Groups (CCGs) and NHS England Specialised Commissioning working collaboratively to commission Sexual Health and HIV Services.

2. With the ending of the Virgin Care Community contract in March 2017, having sought advice from the Competition and Markets Authority, Surrey County Council carried out a full tender process, compliant with European Union Public Contract Regulations and the Council's Procurement Standing Orders. Through the commissioning process, the Council sought to bring together services delivered across three separate Trusts under a single provider in accordance with a National Service Specification for local authorities that was published by the Department of Health in 2013<sup>3</sup>. During the commissioning process the Council and NHS England Specialised Commissioning (NHSESC), which has its own National Specification for procuring HIV Services, agreed to collaborate in order to create a single Sexual Health and HIV Service for Surrey. For the purposes of this report references to the National Service Specification will refer specifically to the Service Specification published by DH to support local authorities in commissioning Sexual Health Services. The contract was awarded to Central & North West London NHS Foundation Trust (CNWL) to deliver a Hub, Spoke and Outreach model. This required a reconfiguration of Sexual Health and HIV Services that precipitated the closure of GUM clinics in the County including the Blanche Heriot Unit at St Peter's Hospital and the Frimley Park Hospital Genito-Urinary Medicine (GUM) Clinic while there was a reduction in provision at a number of other clinics in the County including at the GUM Clinic in Leatherhead. Implementation of the new contract was carried out in three separate phases beginning with the introduction of the new contract on 1 April 2017.

### **Reasons for establishing the Task Group**

3. The Adults and Health Select Committee received a formal referral from Healthwatch Surrey regarding the award of the integrated Sexual Health and HIV Services contract to CNWL which it considered at its meeting on 4 September 2017. The referral, attached as Annex 1 to this report, reflected concerns from patients that the Council and NHSESC had not engaged sufficiently with patients and the public regarding the introduction of an integrated Sexual Health and HIV Service for Surrey. Moreover, the submission of a series of public questions to the Select Committee regarding continuity of care for patients demonstrated that there was widespread interest in the Service. The minutes of the meeting reflect concerns by the Select Committee regarding the level of engagement conducted by commissioners with patients, the public and stakeholders as well as about continuity of care for patients of clinics that had or were scheduled to be closed as part of the reconfiguration. In response to these concerns, the Adults and Health Select Committee established a Task Group with responsibility for reviewing communication and engagement conducted by the Council and NHSESC around the development of the integrated Service and to consider whether CNWL took sufficient steps to achieve continuity of care for patients required to transfer to another clinic.

### **Task Group objectives**

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([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408357/Making\\_it\\_work\\_revised\\_March\\_2015.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)) as accessed on 26 June 2018

<sup>3</sup> Department of Health (2013).

([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/210726/Service\\_Specification\\_with\\_covering\\_note.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf)) as accessed on 26 June 2018

4. The Task Group was asked to consider what lessons could be learned from the commissioning and implementation of the contract and to make recommendations on how this could be done more effectively in the future if appropriate. The scoping document approved by the Select Committee (Annex 2) committed the Task Group to answering the following questions as part of its review:
  - What are the commissioners' responsibilities in respect of consulting on service reconfigurations and how were these met?
  - How was the consultation communicated to residents and service users?
  - How did the views gathered during the consultation inform the development and implementation of the contracts?
  - What steps did CNWL undertake to achieve continuity of care during implementation of the contract and were they sufficient?
  - What communication was undertaken to inform residents and service users about reconfiguration of services arising from the contract?
  - What improvements can be made to the conduct and communication of future consultations on service changes?
  - What lessons can be learned regarding the implementation of the contract?
5. The Sexual Health Services Task Group was formally constituted with the following Membership:
  - Sinead Mooney (Chair)
  - Nick Darby
  - John O'Reilly

<b>Methodology:</b>
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6. The Task Group invited perspectives from across the spectrum of those involved in or impacted by the introduction of the Integrated Service. Both qualitative and quantitative research methods were used to gather evidence supporting the Task Group's commitment to hear from a diverse range of sources. The following section explains the types of research undertaken by the Task Group to gather its evidence, the rationale for the specific research methods pursued and the limitations with some of the evidence gathered.

### **Qualitative Research**

7. To fulfil its remit as laid out in the scoping document the Task Group had to grasp how the Sexual Health and HIV Service was commissioned and implemented. Members also had to understand the rationale for specific decisions taken throughout the process and scrutinise the strategy for engaging with specific groups. The use of qualitative research methods was necessary to gain the level of insight and quality of evidence required for Members to build a nuanced picture of the commissioning process. The success or failure of any attempt to engage is ultimately determined by those whom the communication is directed at and so the Task Group also sought the views of existing patients and stakeholders.

8. The Task Group undertook a number of in-depth interviews with individuals and groups meeting initially with officers from NHSESC, the Council and Healthwatch Surrey to understand how they sought to engage with patients, potential patients and stakeholders throughout the commissioning process. A subsequent meeting took place at the end of the review giving Task Group Members the opportunity to contextualise some of the evidence it had gathered.
9. Members held anonymous telephone interviews with individual service users identified by staff at CNWL as having had their care transferred following closure of the GUM clinics. Contact details of the nine patients who agreed to provide evidence to the review were kindly passed onto the Task Group and the interviews were conducted in half hour slots where each participant was asked the same set of questions. The Task Group also conducted face-to-face interviews with representatives of the Blanche Heriot Unit Patients' Group to ensure the views of this group were considered as part of the review.
10. Interviews were also conducted with GPs, voluntary sector organisations, representatives from Surrey's schools as well as clinical and non-clinical staff from the Service to understand how commissioners engaged them in the development and implementation of the Integrated Service. These also took the form of telephone interviews though different questions were devised for each stakeholder depending on their relationship to the commissioning process. It was during the course of these interviews that the Task Group also spoke to representatives from CNWL to understand the steps that they took to deliver continuity of care for patients.

### **Limitations of Qualitative Research**

11. It is also important to note some of the limitations in the qualitative research undertaken by the Task Group. The research was a resource intensive form of evidence-gathering which placed restrictions on the number of samples that can be gathered using qualitative research. The Task Group had limited time in which to collect evidence to inform its findings and so was required to be selective regarding the number of people that it interviewed. This meant that the Task Group did not have the opportunity to hear from certain patients and stakeholders who may have contributed valuable evidence. The views of those who hadn't been required to transfer their care to another clinic, for example, are not represented in the qualitative research. Another challenge of qualitative research methods is that they only reflect the perspective of those who are willing and able to share their views. This is particularly relevant for the work of the Task Group due to the sensitive and personal nature of sexual health conditions such as HIV. The Task Group is aware that a number of service users and stakeholders were approached by staff from CNWL to contribute their insights to the review but that a number of those contacted were either unwilling or unable to do this. The Task Group would have taken the opportunity to interview more patients had this been possible. Despite Sexual Health and HIV Services being delivered countywide, the majority of patients who agreed to speak to the Task Group had been patients at the Blanche Heriot Unit meaning that the outcomes of the qualitative research are weighted towards the views of those who previously used this clinic.

### **Quantitative Research**

12. Quantitative Research is a form of evidence-gathering which focuses on collecting information and data from a large volume of people and/groups. Statistics generated through quantitative research methods are therefore more likely to reflect the views

of the wider population at large allowing researchers to make more generalised conclusions based on this information. The vast majority of interactions with Sexual Health and HIV Services are from one-time or sporadic users and it is important to ensure that their views are reflected in the Task Group's findings. The Task Group created an online survey asking respondents a series of questions on how they were engaged in the introduction of the new Service. The survey opened on Tuesday 27 February 2018 and closed on Wednesday 21 March 2018, the results of which can be found at Annex 3 to this report. The survey was promoted through various communication channels to achieve widespread dissemination and in doing so gave the opportunity for a further 68 people to contribute their views.

### **Limitations of Quantitative Research**

13. It is important to acknowledge some of the limitations inherent in the data generated through the use of quantitative research methods. The aim of the Task Group's survey was to develop a more general view from patients and the public of communication and engagement undertaken by commissioners regarding the introduction of the integrated service across Surrey and this required the survey to be open for everyone to provide their input. It must also be recognised that over half of those who completed the survey had previously attended the Blanche Heriot Unit where some patients have campaigned actively against the closure of the clinic following the award of the contract to CNWL. The demographic information collected from the survey indicates that 80% of those who responded to the survey are white and that the majority of respondents identify as female. The Task Group is mindful of the fact that the results arising from the survey do not reflect the full spectrum of Surrey residents but was unable to take mitigating action in order to capture a more diverse range of views.

### **Documentary evidence**

14. The Task Group also referenced a number of documents in order to provide a backdrop to the evidence that it collected as part of its review. Officers from the Council and NHSESC volunteered a number of documents providing Members with detailed information on the type and level of engagement that had been undertaken at different stages in the commissioning process. This included an Equality Impact Assessment, correspondence with partner organisations as well as engagement event preparation and outcomes. These documents supported the Task Group in understanding how the Council and NHSESC sought to engage with patients and partners at different stages in the commissioning process. Commissioners also supplied two separate iterations of their joint Communications Plan with CNWL designed to inform patients about forthcoming changes to the delivery of sexual health and HIV services. It was in reviewing these documents that the Task Group arrived at five key areas of focus for understanding engagement and communication around the development and implementation of the new Service. These are:
  - the Sexual Health Needs Assessment;
  - the development of the Service Specification;
  - market engagement;
  - Communicating Changes following award of the contract; and
  - continuity of care for patients whose care was transferred to another clinic.
15. To understand commissioners' responsibilities at each of the five stages identified above, the Task Group also reviewed a number of guidance documents produced by NHS England and the Department of Health outlining expectations in respect of

patient and public participation in the reconfiguration and delivery of healthcare services.

## Section 1 - Engagement and Communication by Commissioners:

16. In recent years NHSE has produced several guidance documents outlining the importance of patient and public involvement in the delivery of healthcare services. Their most recent publication in this area 'Patient and Public Participation in Commissioning Health and Care' emphasises that the involvement of patients and the public enables staff to 'better understand population health needs, and respond to what matters most to people.'<sup>4</sup> Specific guidance produced by NHSE on reconfiguring service changes highlights that 'the strongest proposals are those developed collaboratively by commissioners, providers, local authorities, patients and the public. This helps to build understanding and support... decisions can be reached through open and transparent discussions, where people are able to influence decisions and see how their feedback has been acted upon.'<sup>5</sup> It is in the context outlined within this Guidance that the Task Group considered patient and public participation in establishing the evidence base for an integrated Sexual Health and HIV Service as well as in tailoring the model of Service in accordance with local need.
17. A National Service Specification for commissioning Integrated Sexual Health Services was published by the Department of Health in 2013 to which all local authorities were required to have regard when recommissioning these services<sup>6</sup>. This was followed by Guidance produced by Public Health England in September 2014 (revised in March 2015) advising local authorities on commissioning Sexual Health Services in accordance with the Specification<sup>7</sup>. Collectively the National Service Specification and the Guidance demonstrate an aspiration to introduce more online provision and centralise sexual health and contraceptive services.

### Developing the Sexual Health Needs Assessment

18. To support effective commissioning of healthcare services it is standard practice to conduct a needs assessment to establish the evidence upon which future decisions around the commissioning of services should be based. Information gained through the needs assessment should support local authorities in tailoring the service specification towards local need. Surrey's Sexual Health Needs Assessment (SHNA) identified, for example, that future services should be more accessible, consistent and integrated which commissioners subsequently built into the Service Specification. Guidance published by DH on producing SHNAs states that patients, the public and stakeholders should all be involved in assessing need and suggests a

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<sup>4</sup> NHS England (2017). *Patient and Public Participation in Commissioning Health and Care*. (<https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>) as accessed on 26 June 2018

<sup>5</sup> NHS England (2018). *Planning, Assuring and Delivering Service Changes for Patients*. (<https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>) as accessed on 26 June 2018

<sup>6</sup> Department of Health (2013). ([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/210726/Service\\_Specification\\_with\\_covering\\_note.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf)) as accessed on 26 June 2018

<sup>7</sup> Public Health England (2015). ([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408357/Making\\_it\\_work\\_revised\\_March\\_2015.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)) as accessed on 26 June 2018

number of methods that commissioners may wish to use in order to engage these groups.<sup>8</sup>

19. The Task Group was pleased to identify a number of steps taken by NHSESC and the Council to promote patient, public and stakeholder involvement in the SHNA. The development of the needs assessment was informed by a sub-group of Surrey's Sexual Health Expert Reference Group which includes representation from a range of stakeholders including professionals working directly in sexual health services. The Task Group also heard that, the Council conducted a survey on current and future sexual health services which received nearly 300 responses from professionals and service users. The survey was distributed to all key stakeholders through the Sexual Health Expert Reference Group. Additionally, focus groups were held to gain views on current and future sexual health services including from young parents as well as lesbian, gay, transgender or questioning (LGBTQ) young people. Commissioners emphasised that there are particular challenges associated with engaging users of Sexual Health Services, especially people living with HIV. The Task Group was advised that concerted attempts were made to mitigate these challenges and secure the views of people living with HIV by engaging the expertise of specialist voluntary sector organisations.

### **Developing the Service Specification**

20. The Council also used the development of the Service Specification as an opportunity to involve patients, the public and stakeholders in the commissioning process by seeking their views on how to tailor the integrated Service towards local need. It was during this phase of the commissioning process that the Council and NHSESC sought to establish the case for change which is a crucial part of reconfiguring services.
21. In December 2015, the Council held a 'Sexual Health Concept Day' to present the findings and recommendations from the SHNA, introduce the Service Specification and consult on the model of care. A range of stakeholders were invited to the meeting and invitations were extended to service users through GUM clinics, HIV support services and outreach services. A survey was also published on 'Surrey Says' allowing for further input from patients and the public. The link to this survey was publicised online, emailed to partners, including CCGs while promotional material was also distributed to clinics. In conjunction with the findings of the SHNA, outcomes from the Sexual Health Concept Day and results of the Survey contributed to the development of the Service Specification for an Integrated Sexual Health and HIV Service. Focus groups with young people were also to conduct to support the Council in tailoring the Service Specification to local need.

### **Market Engagement**

22. In 2012 the Government published an Action Note offering detailed guidance on procurement practice for all contracting authorities including local councils. The Action Note highlights the advantages of effective market engagement ahead of starting a formal procurement process<sup>9</sup>. It also details specific advantages that can

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<sup>8</sup> Department of Health (2009). *Sexual Health Needs Assessments: A How to Guide*. (<http://webarchive.nationalarchives.gov.uk/20170106083739/http://www.apho.org.uk/resource/item.aspx?RID=74982>) as accessed on 26 June 2018

<sup>9</sup> Cabinet Office (2012), Procurement Policy Note: Procurement Supporting Growth Supporting Material for Departments, Action Note 04/12 ([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/62097/PN-Procurement-Supporting-Growth.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/62097/PN-Procurement-Supporting-Growth.pdf)) as accessed 26 June 2018

be offered through pre-procurement engagement which includes giving commissioners an insight into the capacity of the market to deliver while also offering prospective bidders the opportunity to ask questions and clarify any issues they may have.

23. Commissioners informed the Task Group that they held a Market Engagement in April 2016 which was attended by several providers understood to be interested in bidding for the new service. Tender submission documents were also made available through an online portal which potential providers could access in order to consider whether they had the expertise and operational capacity to deliver an integrated Service. The online portal also enabled prospective bidders to ask commissioners questions about the contract. Prospective bidders were also invited to attend to the Sexual Health Services Concept Day in December 2015 several of whom sent representatives to the event.
24. Commissioners received 22 submissions of interest from potential providers, nine of whom went onto access the information made available through this portal. Given that CNWL was the only provider to bid for the contract, the Task Group was eager to review what attempts were made to understand the challenges prospective bidders foresaw in delivering the contract.

### **Communicating Changes around the Implementation of the new Contract**

25. Officers stressed that there was limited scope for formal consultation due to constraints around the estate made available within the tender documentation meaning that there were few opportunities for patients to provide their input on specific decisions around aspects of the location of services. Guidance published by NHSE does, however, place clear expectations on commissioners to ensure that patients and the public are informed about the future configuration of services once it is determined that the existing model will be changed. There is also an expectation on outgoing providers to ensure that patients under their care are appraised of arrangements for their ongoing treatment in light of implications arising from the Service being taken over by another provider.
26. Detailed information was provided on steps taken to engage with patients regarding the future shape of Sexual Health and HIV Services. A Communications Plan was circulated to the Task Group outlining commissioners' intentions for engaging with patients on their ongoing care. The Plan details steps that the Council, NHSESC and CNWL took collectively to inform patients, the public and stakeholders about upcoming service changes. This included information events for commissioners, staff and service users as well as dissemination of information through a range of channels including social media, local media outlets as well as leaflets and posters at clinics. The Communications Plan is attached as Annex 4 to this report and includes a full list of the engagement activity undertaken by both commissioners and the provider to inform patients, the public and stakeholders about changes to the Service. A working group for users of the Blanche Heriot Unit was also established at the request of patients and patient representatives which allowed CNWL to respond to specific concerns raised by service users about the potential implications of closure of this specific clinic. The Task Group was pleased to find out that this had helped to establish a dialogue to make tangible contributions to the development of the Integrated Service. This included the introduction of a priority hotline to support people living with HIV in managing their care.

## Continuity of care

27. Closure of the previous GUM clinics was done in three separate phases and, as the Communications Plan demonstrates, the strategy was that information supporting patients in taking decisions on their ongoing care would be provided at their next appointment. Commissioners indicated that, where possible, service users should be given the opportunity to discuss their ongoing care with their consultant. A letter detailing planned changes to the Service and outlining options for their ongoing care was circulated to those patients that were not scheduled to have an appointment before the implementation of the new contract. CNWL also launched a website which hosted an appointment booking system, provided information about the Service and signposted users to how to get in touch with CNWL. Information about changes to the Service were also posted the Healthy Surrey website as well as on both the Blanche Heriot Unit and Frimley Park GUM Clinic websites.

## Conclusions

28. Evidence provided by commissioners demonstrates that a different mechanisms of engagement were used to involve patients, the public and stakeholders at different points in the commissioning process. In accordance with the National Service Specification, the Council sought to engage with specific groups in assessing need for the recommissioning of sexual health and HIV Services although patients, the public and stakeholders were all given the opportunity to provide their insight through a question which were made available in Surrey's GUM clinics. The Task Group was unable to identify any specific duties in respect of engagement around tailoring the Service Specification although it was changed following the outcomes of the Concept Day and the online survey run by commissioners which suggests that the Council took their responsibilities to facilitate continuous engagement with patients seriously. Commissioners also recognised the challenges of engaging with specific groups around Sexual Health and HIV Services, particularly people living with HIV, and used specialist voluntary sector organisations in order to leverage involvement from these groups.
29. The Communications Plan devised collectively by the Council, CNWL and NHSESC to inform patients about upcoming changes to Sexual Health and HIV Services also demonstrates that both commissioners and the provider understood the inevitable concerns that would arise from patients regarding clinic closures and potential anxieties around their ongoing care.

### **Section 2: The View of Patients, the Public and Stakeholders:**

30. The Task Group's research shows a disparity between the efforts made by commissioners to promote engagement in the development of the Integrated Service and the experience of those patients, stakeholders and interested parties who contributed to the review.
31. Similarly, despite steps to make patients aware of options for their ongoing care as detailed in the Communications Plan, it was made clear to the Task Group that arrangements for discussions around continuity of care did not meet patients' expectations. Through its research, the Task Group identified four areas for improvement that would facilitate more meaningful engagement in the commissioning process or support providers in delivering continuity of care during the reconfiguration of services. These are outlined in detail below.

## Mechanisms for Engagement

32. Evidence heard by the Task Group shows that attempts by the Council to involve the public in compiling the SHNA and developing the Service Specification did not achieve the aims set out in NHSE guidance on patient and public participation. This is demonstrated by the following findings from evidence collected during the review:
- Just 12% of those who responded to the Task Group's survey were aware that a review of Sexual Health and HIV Services had taken place in 2015 to inform the development of the SHNA
  - Similarly, 81% of respondents had not seen the questionnaire produced by commissioners in 2015 which sought their views on the SHNA.
  - None of the patients interviewed by the Task Group remember being given the opportunity to contribute their views to SHNA or were aware of the Sexual Health Concept Day although an invite was extended to organisations representing patients.
33. The majority of those who contributed to the Task Group through the online survey and in interviews reported using Sexual Health and HIV Services at least every six months and are therefore more likely to have seen attempts to engage them in the review.
34. Evidence from stakeholders offers an insight into why so few patients reported being given the opportunity to contribute to the review. Clinical and non-clinical staff working in the Service during the course of the review informed the Task Group that the survey was not advertised effectively among patients and contradicted commissioners by suggesting that the questionnaire was not made available at GUM clinics in Surrey.
35. Patients identified numerous channels through which they could have been informed about opportunities to contribute to the commissioning process including by letter, email and through social media. Indeed one of the stakeholders confided in the Task Group that it was hard to identify how the Council had come up with the findings contained within the SHNA. Avenues of engagement not only determine the type and volume of feedback that will be received but also strongly influence perceptions of commissioners' willingness to listen. The Task Group heard from several patients who felt that the Council and NHSESC were not interested in their views with one describing attempts to engage patients as a 'tick box exercise'.
36. A Member of clinical staff within the Service stated that engagement was too focussed on Surrey's vulnerable population rather than seeking to understand the perspective of those who access these services regularly. The result of this was that 'a significant proportion of those who would be impacted by the changes were not given a voice.'
37. The mechanisms that commissioners used for eliciting the views of patients and the public were also criticised by stakeholders. A representative from the Terrence Higgins Trust stated that the methods through which people living with HIV were asked to contribute their views were overly complicated and discouraged many from participating. Furthermore, a member of non-clinical staff who attended some of the focus groups used to collect evidence for the SHNA suggested that these sessions did not capture meaningful responses from those involved.

38. Outcomes from interviews with stakeholders also indicate that certain key partners, as identified within DH Guidance<sup>10</sup>, were not involved in developing the SHNA. Primary Care, for example, was not represented on the Sexual Health Expert Reference Group meaning that the perspective of GPs was not taken into account during the needs assessment. This was highlighted by both GPs who spoke to the Task Group one of whom questioned whether the SHNA could truly reflect need in Surrey given that the view of Primary Care had not been sought. Efforts were made by commissioners to inform key partners about the Sexual Health Concept Day but, although Primary Care were present, a lack of knowledge about this event suggests that correspondence did not always reach its intended recipients.

## Conclusions

39. Few opportunities for patients and the public to provide meaningful input has created lack of investment in the commissioning process from key groups, many of whom do not see their views and experiences reflected in the new Service. As a result, commissioners have been unable to establish a case for change that is recognised by patients and partners something which NHSE Guidance identifies as one of the most important aspects of Service reconfiguration. The Task Group was first alerted to this by Healthwatch Surrey and it remained a consistent theme throughout the review. The results of the online survey, for example, show that 73% of those who responded were unclear on the reasons for the change to services. A similar picture emerged from interviews with patients only one of whom understood what the Council and NHSESC were trying to achieve through the commissioning process. The remaining service users were either unclear on the rationale behind introducing an integrated Service or believed that it was a 'cost-saving measure'.
40. The evidence above suggests that attempts by commissioners to involve patients and the public were too focused, too few and not promoted effectively enough to elicit meaningful engagement in developing the SHNA and tailoring the Service Specification. As commissioners have made clear, securing engagement from Sexual Health Service users, especially people living with HIV, is particularly challenging but the Task Group found no evidence that the outcomes from patient and public participation exercises to understand whether they had yielded meaningful information.

## Recommendations:

41. NHSE Guidance on Service reconfigurations encourages commissioners to assure themselves that they have taken an appropriate and proportionate level of engagement for each stage of the process' but this does not appear to have happened in developing the SHNA or tailoring the Service Specification. The Task Group therefore recommends that the Council and NHSESC review insights captured through methods of public and patient participation so that commissioners can assure themselves that they have received meaningful feedback from a broad cross section of patients and the public.
42. Certain key partners as identified by NHSE Guidance were also not given the opportunity to contribute to the SHNA during its development. In the view of the Task Group GPs are central to assessing need given their role at the heart of healthcare

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<sup>10</sup> Department of Health (2009).

(<http://webarchive.nationalarchives.gov.uk/20170106083739/http://www.apho.org.uk/resource/item.aspx?RID=74982>) as accessed on 26 June 2018.

delivery as well as their specific responsibilities for delivering certain sexual health services. Members are concerned that commissioners did not try to harness the important perspective offered by GPs in the development of the SHNA. By reviewing DH Guidance alongside engagement undertaken by other local authorities in developing their needs assessment the Task Group also identified a number of other partners such as pharmacies, practice nurses and CCGs who commissioners might also have involved in developing the SHNA. The Task Group therefore recommends that the Council and NHSESC review their stakeholder mapping processes to ensure that all key partners are given the opportunity to engage from the beginning of the commissioning cycle. This includes utilising established forums such as the Health and Wellbeing Board and CCG Clinical Executives so that key stakeholders are aware of and have the opportunity to contribute to the commissioning process.

## **Market Engagement**

43. Evidence collected during the review demonstrates that lessons could also be learned by the Council and NHSE in how they sought to engage with the market and stimulate interest among providers. Members were particularly keen to consider this area as part of their review due to the impact that only one provider bidding for the contract had on the structure of the new Service. Concerns regarding the challenges associated with creating a single Sexual Health and HIV Service for Surrey and delivering this within the budget envelope available were highlighted to the Task Group. In fact one stakeholder pointed out that the Council had made the biggest reduction in funding for Sexual Health Services of any local authority nationally. These challenges were also alluded to by the Chief Executive of Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) who indicated that the Trust had withdrawn from the tender submission process because they were unable to make the contract financially viable despite already providing Sexual Health Services through the Blanche Heriot Unit.
44. The Task Group discovered that NHSE and the Council were unaware of the challenges which dissuaded all but one of the prospective bidders until the tender submission process was underway. Information from stakeholders demonstrates that the Council and NHSE did not establish mechanisms for engaging with potential bidders that facilitated a two-way dialogue that would have enabled commissioners to discover the concerns held by potential providers such as ASPH. Other than tender submission documents, contact discussions with potential providers was limited to a Market Engagement Event held by the Council which, as someone who attended the event on behalf of a potential bidder informed the Task Group, was not a forum that enabled a conversation to take place with commissioners around the contract and its potential challenges.
45. The Task Group was also particularly concerned to discover that some of the information included in the tender submission documentation provided by NHSESC was inaccurate. Members learned from a Consultant who had worked in the Service that the number of people receiving treatment for HIV in Surrey was considerably higher than the figure published in the tender documentation. This was later confirmed by commissioners who stated that efforts had been made to verify with providers the number of people receiving treatment for HIV in Surrey although these ultimately proved unsuccessful. The Task Group also heard that a clarification note was included within the tender documentation informing prospective bidders that information was accurate to the best knowledge of commissioners. Data on the number of people receiving treatment for HIV, although given to the best of the Council's knowledge and provided in good faith, gave prospective bidders an

incorrect picture of need in Surrey and appears to have caused some confusion for CNWL when they took over the contract.

## Conclusions

46. Government guidance on procurement processes highlights the importance of promoting dialogue with prospective bidders. The Task Group recognises that the Public Contract Regulations 2015<sup>11</sup> prevent commissioners from entering into dialogue with potential providers once the tender process has commenced. Guidance produced by Central Government, however, states that market engagement should be conducted prior to the tender submission process. This should not be seen simply as a way of imparting information but also a means of commissioners learning what challenges might exist in delivering the contract through mechanisms that facilitate dialogue with those organisations that possess the expertise to deliver on the contract.

## Recommendations

47. In considering efforts undertaken by commissioners to engage the market regarding the Sexual Health and HIV Services contract, the Task Group found that commissioners viewed this stage as a chance to prime the market rather than an opportunity to establish a rapport with prospective bidders. It is therefore recommended that the market engagement stage of the Council and the NHS's respective commissioning cycles facilitate dialogue with potential providers to give commissioners an insight into the challenges of implementing a particular service specification. This will allow commissioners to consider any challenges identified and mitigate these where possible.
48. It is also vital to ensure that the information given to potential providers is correct so that they are able to develop models of care appropriate to the level of need. The Task Group therefore recommends that Surrey County Council and the NHS introduce assurance processes to provide certainty that information contained within tender documentation is accurate.

## Communicating Changes to Sexual Health and HIV Services

49. Evidence collected by the Task Group identified real frustration among patients regarding how they had been informed about the change to Sexual Health and HIV Services in Surrey, particularly around the closure of the three GUM clinics. The picture that emerged during the course of the review was of a disjointed and confused transition to the new contractual arrangements for these services. More than one service user who spoke to the Task Group described the transition as 'chaotic' while another stated that the process left them feeling 'abandoned'.
50. Patients' frustrations regarding how they were informed about changes to how they would receive their care centres on two central concerns:
  - the amount of time they were given to make a decision about their ongoing care; and
  - the information that they were given on which to make this decision.

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<sup>11</sup> Public Contract Regulations 2015.

([http://www.legislation.gov.uk/ukxi/2015/102/pdfs/ukxi\\_20150102\\_en.pdf](http://www.legislation.gov.uk/ukxi/2015/102/pdfs/ukxi_20150102_en.pdf)) as accessed on 26 June 2018

51. Results from the online survey hosted by the Task Group reveal that over 80% of respondents felt that patients should be given a minimum of one month's notice about changes in how healthcare services are delivered. Evidence from service users interviewed by the Task Group reveals that in many cases commissioners' strategy for informing patients about the closure of clinics and options for their ongoing care had made them aware more than a month before the clinic at which they received treatment was scheduled to close.
52. The Task Group did, however, hear from patients who discovered that about changes in service delivery just a few weeks before the clinic which they attended was scheduled to close and were therefore given a limited amount of time to make important decisions about their ongoing care. The testimony of one patient was of particular concern to Members who informed the Task Group that they had been told by text message a week before an appointment that the clinic they used in Leatherhead had closed and that they would be required to go to the Buryfields Clinic in Guildford for this appointment.
53. A consistent feature of all the interviews conducted by the Task Group was the shock that patients felt at finding out that the clinic they attended for treatment would be closing. In all but one of the interviews conducted, the patients who spoke to the Task Group were unaware that a review of Sexual Health and HIV Services had taken place and subsequently that there was the potential for changes in how these would be delivered. Indeed the outcomes of the online survey demonstrates that knowledge of this review was not widespread with 76% of respondents indicating that they were unaware that a review of Sexual Health and HIV Services had been undertaken.
54. This lack of knowledge about the review and the potential threat of closure also seemed to extend to stakeholders with one of the GPs who contributed to the review stating that she only found out that Sexual Health and HIV Services would be changing in February 2017, two months before CNWL took over the contract. Moreover, clinical staff working in the Blanche Heriot Unit advised Members they only found that this clinic would definitely be closing in April 2017.
55. Another key frustration identified by the Task Group was that patients felt that they were not given enough details about future service provision to make informed decisions about their ongoing care. Service users who spoke to the Task Group reported being 'drip-fed' information from clinical and non-clinical staff working within the Service while others stated that the information they received was confusing and lacked clarity. Indeed one of the most significant pieces of evidence collected by the Task Group is that 72% of those who responded to the online survey indicated that they did not feel involved in arrangements for their ongoing care. Testimony from those who worked within the Service during the time of the reconfiguration also highlighted the lack of information made available to patients on which to base decisions about their ongoing care. One of the consultants who worked at the clinic advised Members that leaflets shared with patients to support them in making decisions omitted basic information such as contact details as well as the opening hours of these clinics. Staff working within the Service were, however, unable to provide this clarity to patients because, as another consultant reported to the Task Group, they had not been told what the Service would look like in the future. More than one service user reflected to the Task Group that the reconfiguration was an anxious time for them due to uncertainties around who to contact about replenishing their medication.

56. Successful implementation of the Communication Plan devised by commissioners appears to have been hampered by the approach of outgoing providers to keeping their patients informed. The Task Group heard from a member of staff who had worked at the Leatherhead Clinic during the time of the transfer who expressed concern that the incumbent provider, Virgin Care, were not interested in fulfilling their responsibility to keep service users informed about arrangements for their ongoing care. The Task Group was told that the incumbent provider had no central communications strategy in place to advise service users. Instead this was left to staff at the clinic who took it upon themselves to communicate information about forthcoming changes. In the context of reconfiguring services following the award of a contract to a new provider, it remains the responsibility of the incumbent provider to ensure that patients are made aware of options available to them for their ongoing care once the Service has changed hands.

## **Conclusions**

57. The combined effect of commissioners and incumbent providers not providing patients with enough information about the new Service was to create an information vacuum which, in the absence of a clear narrative from commissioners, was filled by service users. Although the majority of those who responded to the survey indicated that they found out about changes to the Service by being informed by their clinician, 21% of respondents highlighted that they found out through word of mouth while a further 12% became aware of them through information on social media. The outcome of interviews with patients provides some texture to the results of the survey where some of those who spoke to the Task Group reported finding out by text message from friends or fellow patients while another discovered that the clinic they attended was closing through an online petition on the issue.
58. Task Group Members were struck that almost all of the patients who they spoke to reported their shock upon finding out that the clinic where they received treatment would be closing. Although the ineffectiveness of commissioners' attempts at patient and public engagement during the development of the SHNA and the Service Specification contributed to this, it is the view of the Task Group that more could have been done to manage patients' expectations about the future of Sexual Health and HIV Services. Stakeholders who contributed to the review indicated that by the time of the Market Engagement Event in April 2016 it was clear that Sexual Health and HIV Services would be required to undergo significant changes to deliver on the terms of the Service Specification. This suggests that commissioners could have begun to manage expectations at this stage. Commissioners also had six months following the award of the contract during which to advise patients of changes to the Service although this only appears to have begun two months before the implementation of the integrated Service. Although the future shape of Sexual Health and HIV Services was not known at the point the contract was awarded it is the view of Members that commissioners could have initiated a conversation with patients immediately following the award of the contract to make them aware that these Services would be changing.

## **Recommendations**

59. The Task Group understands that informing patients about their ongoing care is the responsibility of the incumbent providers but was unable to identify Guidance or legislation which enshrines these. Evidence contributed to the review suggests that these responsibilities were not adhered to by some of the incumbent providers which

contributed to difficulties informing patients about changes to Service delivery. The Task Group therefore recommends that contracts with providers place clear obligations on them to communicate with service users when exiting contracts. Members also recognise that commissioners, the incoming provider and incumbent providers collectively are important in ensuring that information is made available to patients to support them in making an informed choice about their ongoing care. It is therefore recommended that all parties are involved in developing a central communications plan for informing patients about options for their ongoing care.

## **Continuity of Care**

60. In reviewing continuity of care for patients by CNWL following introduction of the integrated Service a concern was raised consistently by patients and stakeholders regarding access into the Service. A number of patients reported that the Trust's online booking system had experienced technical glitches resulting in large numbers of patients being unable to book appointments through the online system. Both commissioners and representatives from CNWL acknowledged that the booking system had gone down and that this had prevented patients from being able to book appointments. The Task Group heard that this issue was further compounded by the response that some patients appear to have received when they then attempted to book an appointment through CNWL's contact centre. Members were advised that officers in CNWL's contact centre informed service users that the Trust didn't provide services in Surrey.
61. Concerns have also been raised with the Task Group regarding CNWL's ongoing communication with patients. Those interviewed by the Task Group indicated that little or no communication had come from the Trust since it took over the Sexual Health and HIV Services contract. Indeed one service user informed Members of the Task Group that CNWL hadn't made any attempt to engage with them since their care had been transferred from the previous provider. An HIV patient who spoke to the Task Group expressed concern that little information had been made available to them about logistics for the delivery of their medication since online prescriptions had been introduced by CNWL. More generally, patients reported that it has been difficult for them to contact the Trust to resolve problems that occurred during the process of transferring their care. In fact one of the patients who gave evidence reflected that their interview with the Task Group was the only opportunity they had been given to air their views on the integrated Service.

## **Recommendations**

62. Problems with CNWL's online booking system and contact centre only served to stoke anxieties about the future of Sexual Health and HIV Services in the county especially for people living with HIV who were particularly concerned about arrangements for their ongoing care. The Task Group was encouraged to see how seriously both the commissioners and the provider took the problems associated with the online booking system and telephony services but feels that more robust checks should have been undertaken on these to ensure that they were functioning effectively from the outset. It is therefore recommended that NHSESC and the Council require user testing of key points of access into commissioned services to ensure that these are accessible and fully operational from the launch of the Service
63. Members note that communication and engagement by CNWL remains inconsistent which is causing concern and anxiety among some patients. The Task Group notes that a Communications Plan is being developed by CNWL to improve its engagement with key groups and recommends that a copy of this plan is shared with the Health,

### **Section 3 - Conclusions of the Task Group:**

65. Throughout the course of its review, the Task Group heard a huge amount of evidence regarding communication and engagement around all stages of the commissioning of an integrated Sexual Health and HIV Service for Surrey as well as details on how CNWL sought to provide continuity of care and how this was perceived by patients. What has emerged is a complex and often confusing picture around how commissioners and providers sought to engage with patients, the public and stakeholders. The Task Group has, however, sought to keep the experience of patients at the forefront of its review, irrespective of competing priorities or the impact of specific decisions on the commissioning process it is ultimately the experience of patients that determines whether attempts to communicate and engage with them were successful.
66. Evidence collected by the Task Group shows that both the Council and NHSESC did seek to engage with patients and the public around the development and introduction of the integrated Service. The Task Group also recognises that very specific challenges exist for both commissioners and providers in making contact with Sexual Health Service users and that these were exacerbated by the actions of some of the previous providers. Information collected by the Task Group, however, demonstrates that commissioners' attempts to involve patients, the public and stakeholders in the development and introduction of the integrated service were largely unsuccessful. This is clearly demonstrated by the fact that the vast majority of patients who spoke to the Task Group remained unaware that a review had taken place until discovering that the clinic they attended would be shutting.
67. The Task Group's analysis of engagement and communication undertaken by NHSESC and the Council in comparison to NHSE and DH guidance on patient and public participation revealed that commissioners had fallen short of implementing elements of best practice as outlined within these guidance documents. This is particularly true in respect of developing the SHNA and in tailoring the Service Specification where certain key partners were not involved in assessing need and where commissioners appear not to have assessed whether the evidence secured from its engagement mechanisms were meaningful. The Task Group's research has shown that commissioners' attempts at engagement were on a par with that undertaken in the recommissioning of Sexual Health and HIV Services within other local authority areas. The commissioning process has, however, come under the spotlight because of the closure of three GUM clinics. Members of the Task Group were struck by a comment from one of the stakeholders interviewed during the course of the review who stated that efforts to engage service users in the SHNA were not adequate given the extent of the changes which took place. Uncertainty is inherent in the commissioning cycle and so it is crucial that all avenues and eventualities are considered from the beginning of the process. This can only be achieved by extensive engagement with patients, the public and stakeholders so all recognise that they have been given the opportunity to contribute to and influence the shape of new Services.

### **Section 4 - Recommendations**

- i. The Sexual Health Services Task Group recognises the steps taken by Surrey County Council to seek the views of specific groups in developing the Sexual Health Needs

Assessment. However, the Task Group acknowledges that a more informed picture of need in Surrey could have been achieved through broader and more effective engagement. The Task Group therefore **recommends** that Surrey County Council adopts clear expectations for engagement when assessing local need that requires commissioners to:

- a. Council and NHSESC should review insights captured through methods of public and patient participation so that commissioners can assure themselves that they have received meaningful feedback from a broad cross section of patients and the public; and
  - b. the Council and NHSESC review their stakeholder mapping processes to ensure that all key partners are given the opportunity to engage from the beginning of the commissioning cycle. This includes utilising established forums such as the Health and Wellbeing Board and CCG Clinical Executives.
- ii. In considering efforts undertaken by commissioners to engage the market regarding the Sexual Health and HIV Services contract, the Task Group finds that commissioners viewed this stage as a chance to prime the market rather than an opportunity to establish a rapport with prospective bidders. It is therefore **recommended** that the market engagement stage of the Council and the NHS's respective commissioning cycles facilitate dialogue with potential providers within the bounds of the Public Contract Regulations 2015 to give commissioners an insight into the challenges of implementing a particular service specification to allow them to be mitigated where possible.
  - iii. The Task Group heard that the precise number of people who receive treatment for HIV in Surrey did not become apparent to commissioners until after the contract had been awarded to Central and North West London NHS Foundation Trust which further complicated the already challenging process of integrating Sexual Health and HIV Services. It is vital to ensure that the information provided to potential providers is correct so that they are able to develop models of care appropriate to the level of need. The Task Group therefore also **recommends** that Surrey County Council and the NHS introduce assurance processes to provide certainty that information contained within tender documentation is accurate.
  - iv. The Task Group also understands that informing patients about their ongoing care is the responsibility of the incumbent providers but was unable to identify Guidance or legislation which enshrines these. Evidence contributed to the review suggests that these responsibilities were not adhered to by some of the incumbent providers which contributed to difficulties informing patients about changes to Service delivery. The Task Group therefore recommends that contracts with providers place clear obligations on them to communicate with service users when exiting contracts. Members also recognise that commissioners, the incoming provider and incumbent providers collectively are important in ensuring that information is made available to patients to support them in making an informed choice about their ongoing care. It is therefore **recommended** that all parties are involved in developing a central communications plan for informing patients about options for their ongoing care.
  - v. Problems with CNWL's online booking system and contact centre only served to stoke anxieties about the future of Sexual Health and HIV Services in the county especially for people living with HIV who were particularly concerned about arrangements for their ongoing care. The Task Group was encouraged to see how seriously both the commissioners and the provider took the problems associated with

the online booking system and telephony services but feels that more robust checks should have been undertaken on these to ensure that they were functioning effectively from the outset. It is therefore **recommended** that NHSESC and the Council require user testing of key points of access into commissioned services to ensure that these are accessible and fully operational.

- vi. Members note that communication and engagement by CNWL remains inconsistent which is causing concern and anxiety among patients. The Task Group notes that a Communications Plan is being developed by CNWL to improve its engagement with key groups and **recommends** that a copy of this plan is shared with the Health, Integration and Commissioning Select Committee for review by the end of August 2018.
- vii. The Task Group notes NHS England's formal adoption of Healthwatch's 'Five steps to ensure that people in your community have their say' which outlines how to achieve good public engagement when reshaping the delivery of healthcare services. It **recommends** that the Health, Integration and Commissioning Select Committee confirms close adherence to these principles by commissioners when reviewing future changes to service delivery.
- viii. The Task Group **recommends** that the Health, Integration and Commissioning Select Committee reviews the steps taken by Surrey County Council and the NHS to implement these recommendations made by the Task Group and reports these publicly. This includes monitoring delivery against Central and North West London NHS Foundation Trust's action plan for improving communication and engagement with patients, potential patients and stakeholders as outlined in recommendation 8 above.

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**Sources/ background papers:**

Sexual Health Needs Assessments: A How to Guide, Department of Health (2009).

Procurement Policy Note: Procurement Supporting Growth Supporting Material for Departments, Action Note 04/12, Cabinet Office (2012)

Integrated Sexual Health Services: National Service Specification, Department of Health (2013)

Making it Work: A Guide to Whole Systems Commissioning for Sexual Health, Reproductive Health and HIV, Public Health England (2015)

Public Contract Regulations (2015)

Patient and Public Participation in Commissioning Health and Care, NHS England (2017)

Planning, Assuring and Delivering Service Changes for Patients, NHS England (2018)

**Annexes:**

Annex 1 – Referral by Healthwatch Surrey to the Adults and Health Select Committee

Annex 2 – Sexual Health Services Task Group Scoping Document

Annex 3 – Sexual Health Services Task Group Online Survey Results

Annex 4 – Sexual Health Survey Communications Plan