Statement from Stephen Fash, Blanche Heriot Unit Patients' Group

I am very grateful to the Chair of the Committee for allowing me the opportunity, once again, of addressing you on behalf of the Blanche Heriot Unit Patients Group. Those of you who were members of the predecessor Adults & Health Select Committee will recall that I spoke at the meeting of that committee on 4 September 2017. Just to restate my credentials, my interest in this matter is two-fold. I was the Chief Executive of St Peter's Hospital at the time the Blanche Heriot Unit was established as a specialist sexual health, HIV and genito-urinary medicine specialist facility in 1992. Secondly, my daughter has been a patient of the Blanche Heriot Unit for the past 14 years. Like so many patients who attended the Blanche Heriot Unit, my daughter's condition is chronic and susceptible to flare-ups. Without the expert support of Dr Pritchard and her team she would not have been able to work full-time. So I was appalled that this fantastic Unit was under threat for no good reason. As it happens, albeit very late in the day, it was recognised that the service provided for my daughter and other genito-urinary conditions treated at Blanche Heriot fell outside the scope of the new contract and would be retained at St Peter's. My daughter therefore continues to be treated at the Blanche Heriot Unit by Dr Pritchard. I am thankful for that but she and many others were put through considerable anxiety and uncertainty about their continuing care arrangements because of the failure of those responsible for commissioning these services to scope the services provided at the BHU properly and to engage with its patients at any time until after key decisions had been made and only then, I would submit, because of the impact of the Keep Blanche Heriot Unit Open campaign, a campaign which attracted over 3,000 petition signatures. The two so-called Information & Discussion Events that took place last August and September were not consultative – the commissioners simply tried to justify what they had done, whilst those representing the new service provider, were in marketing rather than listening mode. There are thousands of patients who relied on the Blanche Heriot Unit who have lost the service that they trusted and relied upon for their continuing health and wellbeing. These are patients living with HIV, many of whom have co-morbidities or are frail or mobility impaired, and patients who opted to attend the Blanche Heriot Unit to manage their sexual health because of the expertise of the staff, because it was discreet, because it was accessible and convenient.

When I addressed the Select Committee last September I pointed out that in March 2017 Surrey County Council had decided to delay the transfer of the Blanche Heriot Unit service to CNWL to "allow for sufficient time to exit from the contract safely" and to allow NHS England & CNWL "to undertake appropriate levels of consultation with the Blanche Heriot cohort of patients." I said then that neither of those criteria had been met. The Healthwatch Surrey referral had confirmed the inadequacy of the consultation that had taken place with Blanche Heriot patients. and there was even less prospect of a safe exit taking place if the service transferred to CNWL on 1 October 2017 given the obvious lack of preparedness.
I called then for the commissioners to extend the existing contract with Ashford & St Peter's Hospitals NHS Trust for a further six months to enable a proper review of the implications of the planned closure of the BHU to take place in full consultation with its patients, GPs and other stakeholders. That recommendation was not accepted but the Select Committee members were clearly concerned about the apparent failures to engage effectively with patients and stakeholders and set up the Task Group whose report is being presented today.

I applaud and commend this report to you. It is written in polite terms but its findings are clear – that, as a commissioning and engagement process, the award to and implementation of the Integrated Sexual Health & HIV Service for Surrey fell far short of the required standard. It gives me no pleasure to say I told you so – rather I am angry that a botched and incompetent commissioning process led to the closure of a centre of excellence that had served the people of North West Surrey and beyond superbly well for 25 years. Had there been proper enquiry and engagement on the part of the commissioners a different service configuration may have emerged which retained the BHU in that part of the county which the Sexual Health Needs Assessment had identified as having the greatest need.

What has been the consequence of this? The Task Group report refers to the problems with CNWL's online booking system and contact centre. These problems have persisted and there have also been problems with the provision of medication to HIV patients attending Buryfields, particularly where patients had opted for home delivery. It has taken over six months for the online testing service that was such a feature of the CNWL sales pitch to become available. That was six months on from the transfer of the service from the BHU and 12 months since CNWL took over, and promptly closed, most of the community clinics in Surrey. HIV patients who have transferred to the CNWL service at Buryfields Clinic on the outskirts of Guildford now face a long and difficult journey to get there. Those who are mobility impaired find a clinic which does not comply fully with statutory requirements for disability access – an issue we had already pointed out to commissioners. A number of HIV patients, we know, have not found the service satisfactory and have transferred their care to the Wolverton Clinic at Kingston Hospital; other patients have gone elsewhere. We know that patient numbers are significantly down for the Surrey-wide service as a whole, compared with previous attendance figures, and GP workload has increased as a consequence. It is, of course, very worrying if patients are lost to services altogether. The implications in terms of increases in sexually transmitted infections, unplanned pregnancies and the resulting cost transference to other areas of health and public expenditure are serious. A Family Planning Association Report – Unprotected Nation – published in 2015, calculated that every £1 considered a "saving" in sexual and reproductive health social care could actually cost £86 due to the cost of unintended pregnancies and extra sexually transmitted infections.

The Task Group report highlights the abject failure of the commissioners to engage effectively with stakeholders and patients in a process giving rise to major service change. The report refers to guidance documents produced by the Department of Health and NHSE which were clearly not followed to the extent required. I would contend that there were statutory obligations under the NHS Constitution, NHS Act, Local Government Act and Equality Act that were not met. Unfortunately, obfuscation as to when the decision to close the BHU was made, and by whom, meant that any application for judicial review would have been out of time. The Task Group report also highlights the failures in market engagement – inaccurate information provided in the tender submission documentation, lack of dialogue to ascertain why 22 expressions of interest resulted in just one bidder. The one third cut in the service budget was clearly a factor and at the very least one would have expected some dialogue, not least with ASPH and Frimley Park as the existing providers, to ascertain why they did not consider the contract to be viable.

So what is to be done? I do believe that those responsible for these failings should be held to account - that is a matter for the Council and for NHSE. The Task Group has made a number of recommendations which I trust will be fully accepted and implemented. I have shared the report since it entered the public domain with the All-Party Parliamentary Group on Sexual and Reproductive Health which has previously reported its concern about the commissioning process for these services, and whose meeting I attended last week. The BHU Patient Working Group, which was set up at the instigation of the BHU Patients campaign, continues to meet with the commissioners and CNWL to monitor the delivery of the new service. This has proved a valuable forum to represent patients' views and to highlight service access and delivery issues.

I would urge the Select Committee to undertake the closest, continuing scrutiny of the CNWL contract not just in respect of whether it is meeting the set performance and financial targets but, critically, the numbers of patients accessing the service compared with previous attendance figures, the number of teenage pregnancies compared with previous figures, any changes in sexual infection rates and so on. This is particularly important as this is a three year contract with an option for a two year extension. That option should not be actioned unless and until the fullest possible scrutiny of the contract has taken place, such scrutiny to include feedback from patients, GPs and other stakeholders. I have asked before what contingency arrangements the commissioners have put in place in the event either that the contract fails or CNWL pull out (there are examples elsewhere of this happening with providers

who overbid) and that question remains unanswered. I submit that the Task Group report reinforces the need for that question to be answered sooner rather than later.

Statement from Matthew Parris, Healthwatch Surrey

Thank you for the opportunity to comment on these issues which Healthwatch Surrey was able to highlight through a statutory referral to the committee last August.

Firstly, we would like to express our gratitude to members of the task group for the work they have undertaken.

We would also like to take this opportunity to highlight some important findings and pose some questions for committee members to consider ahead of the scrutiny on this item.

Authors of the report assert that *"It is ultimately the experience of patients that determines whether attempts to communicate and engage with them [are] successful"*

- And its findings are clear; attempts to elicit meaningful engagement were not **effective**: they were *"too focused, too few and not promoted effectively enough to elicit meaningful engagement".*
- We very much welcome the report; it is a thorough response to the concerns raised; and the mixed methods approach, in our opinion, struck a good balance between inclusivity and robustness.
- There are some very helpful recommendations: including the suggestion that Healthwatch's 'Five steps to ensure that people… have their say' is adopted as a benchmark for future scrutiny.
- However, we also welcome the on-going interest of the committee in how the provider continues to communicate and engage; as we have – recently - continued to hear concerns about the conduct of that engagement.
- Effective engagement is not always straightforward. It requires an investment in developing expertise. A commitment. And, at times, a pragmaticism. In that context we feel it's important to ask or consider:

  a) Who is accountable? i.e. at SCC and other commissioning organisations
  b) Who will embed learning? i.e. valuable learning from this report
  c) What more assurance processes might we need?

  … to make sure we don't arrive in the same situation in the future.

- Thank you for the opportunity to comment today and thank you for giving a voice to those that *were not* properly involved in significant changes to life-changing and in some cases life-sustaining services.

Statement from Ruth Hutchinson, Surrey County Council

Surrey County Council and NHS England South East welcomed the opportunity to work with the task group and the chance to give a response today.

We recognise there are lessons to be learnt. Both organisations are taking the implementation of the recommendations very seriously and have already started to do this. I will highlight examples from Surrey County Council and then hand over to Sue Whitting, CEO, NHS Commissioning SE, who will demonstrate how this has been done at NHS England South East.

Recommendation 1 asks for commissioners to adopt clear expectations for engagement when assessing local needs.

The public health team have strengthened our stakeholder engagement process and for a recent contract variation on the substance misuse treatment service we ran a substantial consultation exercise engaging with many people with lived experience, families, carers and wider stakeholders using a variety of methods of engagement. We continue to work with our colleagues from Healthwatch and ensure we have ongoing engagement with key parnters such as the CCG clinical executives during this process.

Recommendation two asks that during the market engagement stage of the commissioning cycle there is dialogue with potential partners to give commissioners insight to mitigate challenges.

We recognise that the market can often offer solutions to commissioners. A number of recent procurement exercises have incorporated significant levels of market engagement and made use of different approaches to market such as a negotiated approach which have resulted/will result in services with a high degree of co-design.

It is an unfortunate reality that potential bidders and incumbent providers are reticent to sharing insights and solutions in a wider forum (as they are competitors in the market). In future officers will consider alternative approaches to capture this information prior to tender.

The financial context for the sexual health contract is that the public health funding in Surrey has been reduced by 33% from 2015 to 2020 which has had an impact on all public health commissioned services including this contract. Surrey County Council are direct regarding the financial situation within market engagement both prior to tender exercises and during the life of contracts. We continue to work jointly with providers to modernise services and identify increased efficiencies that minimise impact.

Recommendation 3 asks for assurance processes to be provided to ensure that information contained within tender documentation is accurate.

We acknowledge that contracts have previously lacked detail with regard to expiry and exit. This was recognised during the Sexual Health recommissioning process and as a result new provisions within the contract were incorporated to ensure that all parties are clear as to

respective roles and responsibilities at the end of the contract. This approach has also been used in subsequent procurements.

Commissioners are reliant on service providers to share with them information regarding activity. Greater focus is now given to incorporating meaningful and measurable Key Performance Indicators to support contract monitoring and ensure that detailed activity levels are captured throughout the life of contracts – this will mean we are in a better position to be assured of more accurate information at the point of exit. The procurement department have introduced a contract management framework to manage this.

Recommendation 6 regarding sharing the joint communications plan has already been shared as an appendix to this report for the committee. As commissioners we are working hard to hold the providers to account as well as playing our important role in ensure ongoing timely communications with all our key stakeholders. CNWL have a patient engagement strategy which will be shared prior to and presented at the next patient group meeting.

We look forward to coming back to the Health, Integration and Commissioning Select Committee in order to give a comprehensive update on the performance of the integrated sexual health commissioning contract with CNWL.

Statement from Sue Whiting on behalf of NHS England Specialised Commissioning South

NHS England South would like to thank the Task Group for their report. This report will be shared with the Senior Management Team in NHS England Specialised Commissioning South to ensure that learning can be shared across all of the teams in the South from Cornwall to Kent.

I would also like to thank Surrey County commissioning colleagues for their knowledge and professionalism throughout a challenging procurement bringing three previous service providers into one integrated model of care for Sexual Health and HIV across Surrey.

Undoubtedly levels of engagement with patients and wider stakeholders at an early stage can be improved although as Specialised Commissioning we can only commission from national service specifications, however some aspects such as access to clinics and arrangements for medications could have been asked more specifically.

Recommendation 4iii is a particularly valid point. HARS, the HIV and AIDS Reporting System is a national registry for HIV services that includes number of patients using each service across England. This was used by Specialised Commissioning to obtain numbers of patients to include in the tender. Numbers proved to be inaccurate and this has been fedback to national leads responsible for HIV as well as colleagues locally across the South. Whilst efforts are being made to improve HARS, as a result of this process, Specialised Commissioning in the South will put more robust arrangements in place with service providers to ensure we have accurate patient numbers for future procurements.

People living with HIV often want to preserve their anonymity and status. Healthwatch Surrey has played an important role as a conduit for these patients so that their voice and issues can be heard by commissioners.

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