MINUTES of the meeting of the **HEALTH, INTEGRATION AND COMMISSIONING SELECT COMMITTEE** held at 10.00 am on 7 November 2018 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Friday, 8 March 2019.

(* = in attendance)

Elected Members:

	Mrs Mary Angell
*	Mr Bill Chapman
*	Mr Nick Darby
*	Mr Graham Ellwood
*	Dr Zully Grant-Duff (Chairman)
	Mr Graham Knight
*	Mrs Tina Mountain
*	Mr John O'Reilly
	Mr Wyatt Ramsdale (Vice-Chairman)
*	Mrs Fiona White
*	Dr Andrew Povey
*	Mr Keith Witham

Co-opted Members:

*	Borough Councillor Darryl Ratiram, Surrey Heath Borough Council
*	Borough Councillor Mrs Rachel Turner, Tadworth and Walton
*	Borough Councillor David Wright, Tillingbourne

Substitute Members:

Dr Andrew Povey
Mr Keith Witham

In attendance

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Helen Atkinson, Executive Director of Public Health, Surrey County Council

Andrew Baird, Democratic Services Officer, Surrey County Council

Tumi Banda, Associate Director for Working Age Adult Inpatient Services, Surrey and Borders Partnership NHS, Foundation Trust

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Nick Jones, PwC

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Tim Oliver, Cabinet Lead Member for People

Matthew Parris, Deputy CEO, Healthwatch Surrey

Lorna Payne, Chief Operating Officer, Surrey and Borders Partnership NHS Foundation Trust

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

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

10 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Mrs Mary Angell and Mr Wyatt Ramsdale.

Mr Keith Witham acted as a substitute for Mary Angell.

Dr Andrew Povey acted as a substitute for Wyatt Ramsdale.

11 MINUTES OF THE PREVIOUS MEETING: 4 JULY 2018 [Item 2]

A revised set of minutes were tabled at the meeting. The minutes were approved as a true record of the meeting.

12 DECLARATIONS OF INTEREST [Item 3]

There were none

13 QUESTIONS & PETITIONS [Item 4]

Three public questions were submitted individually to the Committee by Liz Sawyer, Stephen Fash and Sheila Boon. Responses to each of these questions were tabled at the meeting and are attached as Annex 1 to these minutes.

14 RESPONSE FROM THE CABINET TO ISSUES REFERRED BY THE SELECT COMMITTEE [Item 5]

There were none.

15 TEN YEAR STRATEGIC PLAN FOR SURREY [Item 7]

It was agreed that, due to the availability of officers, this item would be considered before Item 6.

Declarations of interests:

There were none

Witnesses:

Helen Atkinson, Executive Director of Public Health, Surrey County Council

Nick Jones, PwC

Tim Oliver, Cabinet Lead Member for People

Matthew Parris, Deputy CEO, Healthwatch Surrey

Key points raised during the discussion

Mr Graham Ellwood entered the meeting at 10.11am

1. The Committee received an introduction to the report from witnesses who informed Members of the reasons why a Ten Year Strategic Plan for Surrey was being developed and the steps that were being taken in order to build a consensus around shared priorities for the health and care system in the County. These priorities would be informed by extensive engagement with stakeholders and the public as well as from the findings of the intelligence-gathering programme being conducted by PwC.

2. Clarity was sought from Members of the Committee on whether the Strategic Plan would focus exclusively on improving the health and wellbeing of Surrey residents. Members heard that the PwC had spoken to a range of partners during the intelligence-gathering exercise which had included seeking the views of public sector partners beyond health and social care. The Strategic Plan would form part of the new 'Vision for Surrey in 2030' which had been developed by Surrey County Council as part of a single plan to align priorities for all public sector investment in Surrey.

3. Members requested further information on how the Strategic Plan would interact with the three Sustainability and Transformation Partnership (STPs) footprints that are wholly or partly in Surrey. The Committee was informed that the Plan would sit above STPs and would be owned by the Health and Wellbeing Board in accordance with its statutory requirement to produce a Joint Health and Wellbeing Strategy. The membership of the Health and Wellbeing Board was being reviewed to incorporate a much wider range of partners whose voices would taken into account on delivery against agreed outcomes.

4. Discussions turned to the length of time that it would take for efforts to improve population health in Surrey to be realised with some Members suggesting that it could take a generation or more to mitigate demand arising from poor lifestyle choices. The Committee heard that it was vital to focus on prevention and early intervention to ensure that the health and social care system can manage demand within the budget envelope available and to reduce health inequalities in the County. Witnesses highlighted that evidence collated by PwC and contained within Surrey's Joint Strategic Needs Assessment had shown that prevention could have a significant impact in the medium term.

5. The Committee highlighted the importance of engaging with the voluntary, community and faith sector (VCFS) as well as with local businesses regarding the development of priorities for the Strategic Plan. Members were advised that PwC had engaged with VCFS organisations seeking their initial view on the plan but that further engagement work would be conducted with them on shaping priorities.

6. The Committee enquired as to whether there was the potential for the Strategic Plan to conflict with the Council's 'Vision for Surrey in 2030'. Members heard that these were part a single strategy for the delivery of public and voluntary sector services in Surrey. There was close alignment between the Strategic Plan being considered by the Select Committee and the five strategies that had been agreed by Cabinet at its meeting on 30 October 2018.

7. Clarity was sought on what role residents and patients had played in identifying priorities for the Strategic Plan. The Committee was informed that it was important to have a framework for engagement to support an informed conversation with the public regarding priorities. A commitment was made to adhere to Healthwatch England's Five Principles for Good Public Engagement when developing Surrey's Ten Year Strategic Plan.

Actions/ further information to be provided

None

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. notes the strategic planning work that has commenced;
ii. provides feedback on the strategic planning work and on the emerging finds presented at the meeting, adding insight from the work the Committee has undertaken to help shape the approach; and
iii. convenes a Task Group to conduct ongoing scrutiny of the 10 Year Strategic Plan for health and social care as it develops and proposes the following areas as an overarching remit for the Task Group:
    a. health inequalities;
    b. outcomes framework; and
    c. how implementation of the proposed plan will deliver against agreed outcomes

16 HEALTH INTEGRATION AND COMMISSIONING SELECT COMMITTEE BULLETIN [Item 6]

Declarations of Interests:

None

Witnesses:

None

Key points raised during the discussion:

1. The item was introduced by the Chairman of the Select Committee who advised that the bulletin was a means of keeping Members updated regarding the work she had undertaken between select committee meetings.

2. A Member enquired about the work of the Improving Healthcare Together 2020 – 2030 Sub-Committee and asked how Members of this Sub-Committee were mitigating the bias of the Chief Executive of Epsom and St Helier University Hospitals Trust. The Chairman advised that the Improving Healthcare Together 2020 – 2030 Programme was the responsibility of commissioners and the Sub-Committee had engaged only with the commissioners which meant that there had been no contact with the Chief Executive of the Trust.

Actions/ further information to be provided:

None

RESOLVED:

None

17 WORKING WITH PATIENTS TO IMPROVE MENTAL HEALTH SERVICES: AN UPDATE ON RECENT WORK BY HEALTHWATCH SURREY [Item 8]

Declarations of Interests:

A non-pecuniary interest was declared by Bill Chapman who advised that he was a Governor of Surrey and Borders Partnership NHS Foundation Trust.

Witnesses:

Tumi Banda, Associate Director for Working Age Adult Inpatient Services, Surrey and Borders Partnership NHS, Foundation Trust

Matthew Parris, Deputy CEO, Healthwatch Surrey

Lorna Payne, Chief Operating Officer, Surrey and Borders Partnership NHS Foundation Trust

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

Key points raised during the discussion:

1. The Committee received an introduction on the role of Healthwatch Surrey (HWSy) within the health and social care system in the County. Members heard that Healthwatch used various methods to gain insights into patient experiences around the delivery of specific

services making recommendations to commissioners and providers in response to these.

2. Further information was also provided on the Enter and View visit to the Abraham Cowley Unit (ACU), a mental health inpatient unit operated by Surrey and Borders Partnership NHS Foundation Trust. The Committee heard the reasons behind HWSy's decision to invoke its statutory power to undertake an Enter and View visit at the unit and were informed of the methodology used and engagement conducted by HWSy to collect evidence during their visits. SABP had been very responsive in seeking to address the problems identified by HWSy officers during their visit but that there appeared to be some long-term challenges that it was necessary for the Trust to address regarding its inpatient provision. The Committee was informed that staffing levels and the environment were the two key challenges at the ACU.

3. Representatives from SABP were given the opportunity to respond to the findings of the Enter and View Report. It was acknowledged that the capacity to recruit and retain good quality nursing staff as well as the environment created significant challenges for the provision of inpatient care at the ACU. Members heard that plans were being developed to improve the quality of the environment in working age adult wards through rebuilding and refurbishment alongside a building programme to improve inpatient mental health service units across the county. The Committee was advised that SABP had commissioned an independent review to make recommendations on how the Trust could improve patient experiences at the ACU.

4. Discussions turned to the use of dormitories to house patients at the ACU and the Committee was advised that many patients had reported that sleeping in dormitories had impacted negatively on them. Members of the Committee requested that SABP commit to a clear timescale on when dormitories would be replaced with single occupancy rooms. Representatives from SABP acknowledged that dormitories were not optimum for accommodating mental health inpatients but stressed that the sums associated with refurbishing the ACU were significant. The Trust was progressing its plans to have three mental health inpatient hospitals in Surrey but already had funding in place to refurbish the ACU irrespective of whether they received financial backing for the three hospital solution. Members were advised that, when taking demand into account, SABP's inpatient services were currently over 100% occupancy and that a plan was needed to build some capacity within the Trust's existing provision to allow the refurbishment work to commence.

5. Discussions turned to the significant number of negative experiences recorded by HWSy from among those who had used mental health inpatient services in Surrey. Representatives from SABP informed the

Committee that the majority of those who used mental health inpatient services were there involuntarily having been sectioned under the Mental Health Act. As such, their experiences would necessarily be less positive when compared to those who use other types of healthcare services such as Primary Care. Representatives from SABP confirmed that the Trust also recorded patient experience and used this feedback to inform and improve their services which had led to improvements in mental health inpatient provision over recent years.

6. Members discussed funding for mental health services in Surrey highlighting that less was spent per head in the County than in many other local authority areas. The Committee highlighted the need to lobby Government to ensure that Surrey got a fair deal from allocations that had been made available by the Department of Health and Social Care in order to establish parity of esteem with physical health. It was agreed that the Committee should write to the Secretary of State for Health and Social Care regarding the availability of funding for mental health services in Surrey.

7. Conversations took place regarding specific actions that the Committee could hold SABP accountable against for improving the experience of those who used inpatient mental health services in Surrey. Members heard that the Trust had produced an Improvement Plan in response to the Care Quality Commission report on the ACU which the Committee could use to hold SABP account for its performance. It was agreed that the Improvement Plan would be circulated to the Committee for this purpose.

Actions/further information to be provided:

1. SABP Improvement Plan in response to CQC inspection report on the Abraham Cowley Unit to be circulated to the Committee.

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. recognises that mental health provision is comprised of various service areas including prevention, resilience, CAMHS, community and inpatient services. The Committee restated its commitment to conduct ongoing scrutiny of mental health provision in Surrey, in particular through direct engagement with service users, commissioners and providers, for review at its March meeting;

ii. restates its commitment to conduct ongoing scrutiny of mental health provision in Surrey, in particular through direct engagement with service users, commissioners and providers, for review at its March meeting; and

iii. considers the key points raised and recommendations made at the Adult and Health Select Committee meeting of 9 November 2017 when planning further scrutiny of inpatient mental health services, in particular reviewing how performance is assessed from the patients' perspective.

18 SEXUAL HEALTH AND HIV SERVICES CONTRACT [Item 9]

Declarations of Interests:

None

Witnesses:

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Matthew Parris, Deputy CEO, Healthwatch Surrey

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

Key points raised during the discussion:

1. The Committee acknowledged that significant improvements had been made in the provision of Sexual Health and HIV Services in the intervening period since the Service had last been scrutinised. Concern was, however, expressed about access into the service for those who feel less comfortable booking appointments or requesting testing kits online. Members were advised that online was one of a number of access points into the Service for residents and that Central and North West London NHS Foundation Trust (CNWL) had adapted services to ensure accessibility.

2. Members sought clarity on progress that had been made to resolve some of the initial issues experienced by the service when the contract commenced with CNWL such as disabled access to clinics, increase in GP referrals and problems with the telephone system. The Committee heard that steps had been taken to address these issues in consultation with patients and stakeholders. This had included work with Disabled Go and Surrey Coalition of Disabled People who had made recommendations regarding how to improve the accessibility of clinics to those with disabilities.

3. Discussions turned to the availability of services through the hub, spoke and outreach model implemented by CNWL. All of the spokes were fully operational and consultants had all been trained to treat

both GUM and sexual health conditions which meant that there was greater flexibility within the Service.

4. The Committee asked whether Sexual Health and HIV Services in Surrey were better than they had been before CNWL took over the contract in April 2017. Members were advised that the new service model offered a variety of access points into the service, in particular the use of online services to be able to cover the geography of Surrey. This meant that consultant time could be targeted more effectively towards those with the most acute conditions which was vital given the reduced financial envelope available to commission sexual health services. Witnesses also emphasised the challenges inherent in bringing three separate services together into a single Sexual Health and HIV Service for Surrey.

5. Members heard that HWSy had held an event at Buryfields Clinic in Guildford to find out more about the experiences of patients and that, among a very small sample, the majority who spoke to HWSy indicated that they were very happy with the services they had received. Some patients had, however, expressed concern about reductions in the number of Sexual Health Advisors. Representatives from CNWL stated that patients in HIV treatment who have an undetectable viral load could not pass on the virus and the service had very good partner notification rates. CNWL had retained one SHA but it was felt that resources previously allocated to SHAs would be better targeted elsewhere.

Actions/ further information to be provided:

None

RESOLVED:

That the Health, Integration and Commissioning Select Committee notes the performance of the sexual health and HIV treatment and care service contracts.

19 RESPONSE FROM NHS ENGLAND SPECIALISED COMMISSIONING AND SURREY COUNTY COUNCIL TO RECOMMENDATIONS MADE BY THE HEALTH INTEGRATION AND COMMISSIONING SELECT COMMITTEE [Item 10]

Declarations of Interests:

None

Witnesses:

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Matthew Parris, Deputy CEO, Healthwatch Surrey

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

Key points raised during the discussion:

1. The Committee commended CNWL, NHSE Specialised Commissioning and Surrey County Council for their work in implementing recommendations made by the Health Integration and Commissioning Select Committee.

2. Members were informed that the NHSE Specialised Commissioning South had put all of its staff through patient engagement training in response to the work of the Sexual Health Services Task Group and the recommendations made by the Select Committee.

Actions/ further information to be provided:

None

RESOLVED:

That the Health Integration and Commissioning Select Committee notes the progress made by Central and North West London NHS Foundation Trust, NHS England Specialised Commissioning and Surrey County Council within the implementation of its recommendations.

20 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of Interest:

None

Witnesses:

None

Key points raised during the discussions:

None

Actions/ further information to be provided:

None

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. reviews items that it is due to consider at future meetings; and

ii. reviews progress against actions and recommendations as captured within the Committee's Recommendations Tracker.

21 DATE OF THE NEXT MEETING [Item 12]

The Committee noted that its next meeting would be held on 8 March 2019.

Meeting ended at: 12.53 pm

Chairman

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ITEM 4

Questions to the Health, Integration and Commissioning Select Committee – 7 November 2018

1. Question submitted by Liz Sawyer

What metrics do the committee use to assess whether the services commissioned by Surrey County Council are meeting the Council's sexual health priorities and to assess whether the sexual health of Surrey residents is improving?

Response

The Committee has a scrutiny function and in this regard exercises collective judgement when requesting and reviewing information and data from health commissioners and providers.

The Committee has asked requested a response from Surrey County Council regarding the metrics that they use to assess performance in delivering against sexual health priorities and has received the following response:

'The performance and quality of the sexual health service are monitored through three methods:

- the Public Health Outcomes Framework indicators (PHOF) – full list below
- quarterly monitoring reports, that include key performance indicators (KPIs) presented at contract meetings (full list below), and
- patient and stakeholder feedback. Patient feedback is gathered in a number of ways including via anonymous customer feedback cards.

An update on performance against the PHOF and contracted activity for clinic appointments and online testing can been found in Performance and Quality section of the HICSC report. The report is presented at item 9 of the agenda

Public Health Outcomes Framework indicators (PHOF)

Indicator	Explanation
Syphilis diagnostic rate / 100,000	All syphilis diagnoses among people accessing specialist and non-specialist sexual health services* in England who are also residents in England, expressed as a rate per 100,000 population.
Gonorrhoea diagnostic rate / 100,000	All gonorrhoea diagnoses among people accessing sexual health services* in England who are also residents in England, expressed as a rate per 100,000 population.
Chlamydia detection rate / 100,000 aged 15-24	All chlamydia diagnoses in 15 to 24 year olds attending specialist and non-specialist sexual health

Indicator	Explanation
	services (SHSs)*, who are residents in England, expressed as a rate per 100,000 population
Chlamydia proportion aged 15-24 screened	All chlamydia tests (asymptomatic screens and symptomatic tests) undertaken in 15 to 24 year olds attending specialist and non-specialist SHSs* who are residents in England.
New STI diagnoses (exc chlamydia aged <25) / 100,000	STI diagnoses (excluding chlamydia in under 25 year olds) among people accessing specialist and non-specialist sexual health services* in England. Data are expressed as a rate per 100,000 population aged 15 to 64 years.
HIV testing coverage, total (%)	Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis.
HIV late diagnosis (%)	Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis.
New HIV diagnosis rate / 100,000 aged 15+	All new HIV diagnoses among adults (aged 15 years or more) in the UK, expressed as a rate per 100,000 population
HIV diagnosed prevalence rate / 1,000 aged 15-59	People aged 15 to 59 years seen at HIV services in the UK, expressed as a rate per 1,000 population.
Population vaccination coverage – HPV vaccination coverage for one dose	All girls aged 12-13 years who have received the first (priming) dose of the HPV vaccine within each reporting area (local authority - LA) as a percentage of all girls aged 12-13 years within each area
Under 25s repeat abortions (%)	Percentage of abortions in women aged under 25 years that involve a women who has had a previous abortion in any year.
Abortions under 10 weeks (%)	Percentage of all NHS-funded abortions performed under 10 weeks gestation
Total prescribed LARC excluding injections rate / 1,000	Crude rate of long acting reversible contraception (LARC) excluding injections prescribed by GP and Sexual and Reproductive Health Services per 1,000 resident female population aged 15-44 years
Under 18s conception rate / 1,000	Conceptions in women aged under 18 per 1,000 females aged 15-17. Numerator is the number of pregnancies that occur in women aged under 18 and result in either one or more live or still births or a legal abortion

Indicator	Explanation
Under 18s conceptions leading to abortion (%)	The percentage of conceptions to those aged under 18 years that led to an abortion
Sexual offences rate / 1,000	Rate of sexual offences based on police recorded crime data per 1,000 population

Key Performance Indicators

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
Clinical Management				
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment undertaken[1]	100%	BASHH Standard 1[2]	Clinical Audit	Remedial Action Plan
Monitor percentage of first time service user (of clinical based services) offered and accepting an HIV test		For local determination (To support Public Health Outcome Framework 3.4)	GUMCAD	Remedial Action Plan
Percentage of routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within seven working days of a specimen being taken	100%	BASHH Standard 4	Clinical Audit	Remedial Action Plan
Ratio of contacts per gonorrhoea index case, such that the attendance of these contacts at a Level 1, 2 or 3 service was documented as reported by the index case, or	0.6 contacts, and documented within four weeks of the date of the first PN discussion[3] [4]	BASHH Statement on Partner Notification for Sexually	Clinical Audit	Remedial Action Plan

[1] Does not include individuals accessing self-managed care (Section 3.2.1)

[2] BASHH (British Association Sexual Health & HIV) and MEDFASH (2010). *Standards for the Management of Sexually Transmitted Infections (*http://www.medfash.org.uk/publications)

[3] Corrigendum *BASHH Statement on Partner Notification for Sexually Transmissible Infections,* May 2013 (http://www.bashh.org/documents/Corrigendum%20BASHH%20Statement%20on%20Partner%20Notification%20for%20Sexually%20Transmissible%20Infections.pdf)

[4] Current standards recommend 0.4 and 0.6 contacts per index case dependent upon area of service delivery. However, Commissioners may consider aspirational targets of 0.6 and 0.8 contacts per index case in future, as evidenced by *Turner K. et al*, 2010 (http://www.bmj.com/content/342/bmj.c7250)

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
by a HCW, within four weeks of the date of the first PN discussion (within 12 weeks for HIV)		Transmissible Infections[25]		
Ratio of contacts of chlamydia index cases whose attendance at a Level 1, 2 or 3 service was documented as reported by the index case, or by a HCW, within four weeks of the date of the first PN discussion	At least 0.6 contacts per index case for all clinics (in and outside London), and documented within four weeks of the date of the first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections NCSP Standard 4	Clinical Audit	Remedial Action Plan
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 HCW, within four weeks of first PN 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 NCSP Standard 4	Clinical Audit	Remedial Action Plan
Documented evidence within clinical records that PN 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%	BHIVA Standard 7[5]	Clinical Audit	Remedial Action Plan
Documented PN outcomes or a progress update at 12 weeks after the start of the process	90%	BHIVA Standard 7	Clinical Audit	Remedial Action Plan
Monitor period of time from consultation to receipt of results by service user		BASHH Standard 5	Clinical Audit	Remedial Action Plan
Percentage of women having access to and availability of the full range of contraceptive	100%	FSRH Standard 2[6]	Clinical Audit	Remedial Action Plan

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

[6] Faculty of Sexual & Reproductive Healthcare (2013). *Service Standards for Sexual and Reproductive Healthcare* (http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
method (including choice within products)				
Monitor percentage of LARCs prescribed as a proportion of all contraceptives by age			Bi-annually	Remedial Action Plan
Percentage of women who have access to urgent contraceptive advice and services (including emergency contraception) within 48 hours of contacting the service			Bi-annually	Remedial Action Plan
Percentage of women including vulnerable groups (for example teenage mothers and looked after children) who have access to LARC method of choice within 15 working days of contacting service[32]			Bi-annually	Remedial Action Plan

Improving Productivity				
Percentage of staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant update requirements	100%	BASHH Standard 2	For local determination	Remedial Action Plan
Percentage of nurses dual trained to deliver contraceptive (including LARC methods) and GUM services		For local determination	For local determination	Remedial Action Plan
Training for wider sexual health workforce	Training needs analysis to be completed and action plan developed in collaboration with commissioners		Annually	
GP and pharmacy engagement	Attendance at CPPE and GP development events		Annually	

Establish a county wide sexual health network with a health improvement component to include commissioners, clinicians, key health care professionals and the wider partners	Evidence of clinical network including TOR, meeting agendas and action notes		Annually	
Surrey Safeguarding board attendance	Contribute to the priorities of both safeguarding boards in Surrey and attend sub-groups where appropriate		Annually	
Under 25s Services				
Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	Local tolerance of 1900/100,000	Public Health Outcome Framework measure (3.2)	CTAD Data	Remedial Action Plan
Percentage of all under 25 year olds screened for chlamydia	At least 75%of new attendances[7]	Contributes towards Public Health Outcome Framework measure (3.2)	For local determination (Drawing on CTAD where appropriate)	Remedial Action Plan
Percentage of all results notified to the young person within 10 working days (from test date)	At least 90%	NCSP Standard 4	For local determination	Remedial Action Plan
Percentage of positive patients who received treatment within six weeks of test dates	At least 95%	NCSP Standard 4	For local determination	Remedial Action Plan
Number of new registrations, young people repeat visiting and total repeat visits to c-card outlets by age/gender			Quarterly	Remedial Action Plan
Service User Experience across all services provided				
Maintain/achieve *You're Welcome* accreditation	100%	National Expectation	Within first year of contract and then every three years subsequently	Remedial Action Plan
Evidence of at least one user experience survey annually	100%	For local determination	Annually	Remedial Action Plan

[7] It is suggested that delivery of this threshold would be supported by offering chlamydia screening to 100% attendees on an opt out basis - Local information can be used to inform proportion of all attendances that should be screened for chlamydia based on first/follow up attendance ratio.

Percentage of service user feedback on surveys that rates satisfaction as good or excellent	70%	For local determination	Annually	Remedial Action Plan
Quality Outcomes Indicators	**Threshold**	**Technical Guidance Reference (if applicable)**	**Method and frequency of Measurement**	**Consequence of Breach**
Evidence of improvements made to service as a result of user feedback	Demonstrable evidence of improvements and changes made to service delivery in response to feedback	BASHH Standard 9	For local determination	Remedial Action Plan
Number of service users making formal complaints about the service (verbal or written)	Provider to notify Commissioner in accordance with *Incidents Requiring Reporting Procedure Section* - Appendix G	BASHH Standard 9	For local determination	Remedial Action Performance
Reducing Inequalities				
An Equality Impact Assessment (EIA) is undertaken and outcomes utilised to inform forward year planning	Completion of EIA	Locally Determined	Bi-annually	Remedial Action Plan
Provider to demonstrate that all functions and policies are equality impact assessed	Agreed programme to achieve compliance	Locally Determined	For local determination	Remedial Action Plan
Number of individual face to face contacts, non face to face contacts and sessions made by outreach services conducted in areas of high deprivation or aimed at vulnerable groups (MSM, Black African, Sex Workers and Young People including young parents and Looked After Children)	For local determination	Locally Determined	For local determination	Remedial Action Plan
Number of individual face to face contacts, non face to face contacts and sessions made by outreach services (to include clinic/ drop-in sessions)	For local determination	Locally Determined	For local determination	Remedial Action Plan

conducted in Further Education and University settings				
Provider to make available to clients, where appropriate, Chem Sex Packs (which includes, condoms, lube, information where to get support, some packs include syringes, spoons, gloves etc)	For local determination	Locally Determined	For local determination	Remedial Action Plan
Provider to provide basic brief advice with regards to safe sex whilst under the influence and other related topics.	For local determination	Locally Determined	For local determination	Remedial Action Plan
The provider is able to report by geography as specified by the commissioner to help understand how the services are tackling inequalities/working within areas of highest need	For local determination	Locally Determined	For local determination	Remedial Action Plan
The provider is able to report on the number of looked after children accessing the service and those with special educational need or disability	For local determination	Locally Determined	For local determination	Remedial Action Plan
Quality Outcomes Indicators	**Threshold**	**Technical Guidance Reference (if applicable)**	**Method and frequency of Measurement**	**Consequence of Breach**
Access				
Percentage of clients accessing service to be seen within 48 hours of contacting the service	85%	Locally Determined	For local determination	Remedial Action Plan
Percentage of people offered an appointment, or walk-in, within 48 hours of contacting a provider	98%	BASHH Standard 1	For local determination	Remedial Action Plan
Percentage of users experiencing waiting times in clinics of > 2 hours	For local determination	For local determination	For local determination	Remedial Action Plan
Percentage of clients waiting longer than *(to be agreed locally)* from booking to appointment	For local determination	Locally Determined	For local determination	Remedial Action Plan

Increase in the number of men accessing services	For local determination	Locally Determined	For local determination	Remedial Action Plan

Care pathways with other organisations to include partner notification and/or linked services (e.g. alcohol, mental health etc.) are clearly defined	Pathways established	BASHH Standard 7	For local determination	Remedial Action Plan
Fast track referral pathway established for professionals working with vulnerable young people i.e. young parents, those at risk of CSE, Looked After Children	Pathways established		For local determination	Remedial Action Plan
Percentage of specialist SRH referrals from general practice seen within 18 weeks of referral	For local determination	Locally Determined	For local determination	Remedial Action Plan
Percentage of psychosexual clients seen within 18 weeks of referral[8]	For local determination	Locally Determined	For local determination	Remedial Action Plan

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
7 November 2018

[8] This indicator may be omitted if the provision of psychosexual services forms part of a separate agreement

2. Question submitted by Stephen Fash

In view of the serious shortcomings identified in the commissioning process by the Sexual Health Services Task Group (Final Report received by the HIC Select Committee on 4 July 2018) – particularly the lack of effective engagement and communication with service users, GPs and other stakeholders and the failure to explore why all but one of the 22 prospective bidders chose not to submit a tender leading to the contract being awarded, uncontested, to a single bidder – will Surrey County Council, as the lead commissioner for the integrated Sexual Health & HIV Service for Surrey confirm that it will not extend the existing contract with Central & North West London NHS Foundation Trust for a further two years, as it is understood that the said contract allows or, if it is so minded, will not do so without undertaking full consultation with service users, GPs and stakeholders and will take full account of the views received in public session before making any such decision?

Response

The Committee has asked Surrey County Council to respond to your question and has received the following response:

'Surrey County Council has a process for the agreement of contract extensions. Any recommendation to extend a contract would take into account contract quality and performance (which for this contract includes engagement with residents and stakeholders) and value for money. This contract is jointly commissioned and therefore SCC and NHSE would discuss any extension to the contract and jointly agree any decision.'

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
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3. Question Submitted by Sheila Boon

Although CNWL were awarded the Surrey contract with effect from April 2017, it has only been meeting its full contract commitment since the closure of the Blanche Heriot Unit in October 2017 – how does the level of patient activity at the services operated by CNWL over the past year compare with the equivalent period in 2015/16 and what are the financial implications of work displaced to GPs or to other service providers?

Response

The Committee has asked Surrey County Council to respond to your question and has received the following response:

'CNWL are providing services with a new model of care. The service model commissioned has a greater focus on prevention and innovation meaning a shift from the traditional service model of face-to-face consultations to a service 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. As the contract requirements are different, patient activity is therefore of a very different nature from the previous contracts held in 2015/16.

An update on performance against contracted activity for clinic appointments and online testing can been found in Performance and Quality section of the HICSC report. The report is presented at item 9 of the agenda.

As well as the CNWL contract, public health also commission some sexual health services from GPs and pharmacies. Over the past year, there has been an increase in long acting reversible contraception (LARC) spend in general practice. The sexual health commissioner is working with GPs, the LMC (Local Medical Committee) and the sexual health service on a review of LARC across the county with a particular focus on complex procedures.'

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
7 November 2018

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