Written evidence from Me Stephen Fash

from Stephen Fash, former Chief Executive, Ashford & St Peter’s Hospitals NHS Trust

Executive summary

This submission is based on my recent experience of arguing against the closure of the Blanche Heriot Unit (BHU) at St Peter’s Hospital, Chertsey which was the result of a combination of factors:

- Inclusion of clinical sexual health services in the transfer of responsibility for Public Health from the NHS to Local Authorities under the Health & Social Care Act 2012
- Lack of review of funding for public health on transfer to local authorities with the result that Surrey has the lowest per capita funding in England
- 6% cut in public health budgets imposed by the then Chancellor of the Exchequer in 2015
- General lack of protection of public health budgets under local authority financial arrangements
- Linked commissioning arrangements with NHS England in respect of HIV services thereby exposing HIV services where they are integrated with sexual health services to funding cuts
- Specifically in Surrey, a deeply flawed commissioning process which led to Healthwatch Surrey exercising their statutory power to refer the matter to the Surrey County Council Adults and Health Select Committee due to concerns about the inadequacy of consultation with service users and stakeholders. These concerns were echoed by a vigorous campaign by BHU patients, GPs and other stakeholders who valued the excellent service provided by the BHU for over 25 years. It led to Surrey County Council (SCC) setting up a Sexual Health Service Task Group (Task Group) of three councillors to review the commissioning arrangements and identify lessons to be learned. The Task Group reported in July 2018 and their report is a damming indictment of a grossly inadequate commissioning process.

Introduction

1. My interest in this matter was two-fold. As the Chief Executive of St Peter’s Hospital at the time, I was responsible for establishing the BHU as a Consultant-led sexual health, HIV and genito-urinary medicine specialist facility in 1992. This was at the request of the Regional Health Authority with funding provided through the North West Surrey Health Authority. A second hospital based clinic was established at Frimley Park Hospital which was also forced to close - in June 2017. My second point of interest was that my daughter had been a BHU patient for 14 years. Like many patients who attended the Blanche Heriot Unit, her condition was chronic and susceptible to flare-ups. Without the expert support of Dr Pritchard, the Consultant in charge of the BHU and her team, my daughter would not have been able to work full-time – many with her condition do not because the pain and fatigue are too intense. I was appalled that this fantastic Unit should be under threat for no apparent reason. Certainly I could see no clinical rationale for closing a Unit which was held in such high esteem by its patients, GPs and other clinical colleagues.
2. In the event, albeit very late in the day, it was recognised that the service provided for my daughter and other genito-urinary conditions treated at the BHU fell outside the scope of the new contract and would be retained at St Peter’s. My daughter therefore continues to be treated at St Peter’s Hospital 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. Through that campaign I have become acquainted with HIV patients who are particularly vulnerable due to co-morbidities, physical or mental frailty, mobility impairment or financial circumstances and whose access to care has been severely compromised by the closure of BHU in October 2017.

Blanche Heriot Unit

3. The BHU served a large population in North West Surrey principally from Woking, Runnymede and Spelthorne, although patients also attended from further afield given the Unit’s accessibility and expert, discreet service. This was a population that, by the commissioners’ own sexual health needs assessment, had the greatest need in Surrey – Runnymede and Spelthorne have historically higher than the national average rates of under 18 conceptions, and Woking has a higher than national rate of HIV prevalence. The Blanche Heriot Unit had some 15,000 patient attendances per annum. A great many of the patients attending the Blanche Heriot Unit had longstanding conditions requiring regular review and attention. The lack of detailed activity data and, indeed any scoping of the service provided by the BHU, was a major failing of the SCC/NHS England procurement exercise. The Unit was fully integrated with St Peter’s Hospital with clinical inter-connectivity with maternity, obstetrics & gynaecology, A&E, pathology, dermatology, pain management, physiotherapy and - for inpatient admissions - general medicine and intensive care. It was a training resource for junior doctors, GPs, nursing staff and other health care professionals. The benefit of such integrated working and the ready availability of specialist advice, particularly on HIV, to other clinicians at this large DGH have now been lost.

The commissioning process

4. In its invitation to tender for an integrated Surrey Sexual Health & HIV service contract, SCC cut the budget by 33%. NHS England, which commissions HIV services, did not cut its funding but HIV services were adversely affected by the consequential closure of the BHU and the equivalent clinic at Frimley Park Hospital. None of the preparatory work for developing the tender envisaged a 33% cut in the service budget, nor the closure of the clinics at St Peter’s and Frimley Park. BHU patients were not invited to participate in the tender preparation process. None of the previous providers – Virgin Care (for the community clinics), Ashford & St Peter’s Hospitals NHS Foundation Trust (for the BHU) and Frimley Health Trust (for the Frimley clinic) – bid for the contract because it was not viable at the reduced funding level. Central & North West London NHS Trust (CNWL) were the sole bidder. The Task Group report highlights the failures in market engagement – inaccurate information provided in the tender submission documentation and the lack of dialogue to ascertain why 22 expressions of interest resulted in just one bidder.
5. “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.”

(HHSCT Final Report, 4 July 2018 – Surrey County Council)

6. The Task Group report also chronicles 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.

7. The proprietary of awarding a contract to a single bidder appears not to have been questioned by the commissioners either at officer or councillor level. It is not clear whether appropriate due diligence was undertaken. At the time CNWL were struggling financially. The Trust Board minutes noted that the predominant challenge for 2017/18 was “to close the deficit of £3.8m which requires the Trust to deliver its £30m savings programme.” Neither Frimley nor Ashford & St Peter’s were in deficit, yet they took the prudent decision not to bid for a contract that was not financially viable. As a Central London provider, CNWL were completely unfamiliar with Surrey, particularly the distances between locations and the shortcomings in public transport.

Outcome

8. The commissioners showed no apparent interest in the service model that CNWL proposed to apply in Surrey, focusing only on outcome measures. The nonsense of applying commercial considerations to prevent public access to information about the award of a contract funded by the taxpayer to a taxpayer funded NHS organisation means that we know very little about the costing and robustness of the bid made by CNWL, nor the level of scrutiny undertaken by the commissioners. What we do know is that services have been hollowed out. On taking over the former Virgin Care contract in April 2017, CNWL closed over 30 contraception and sexual health clinics – going from 17 locations to just 3. There is great concern among GPs and health professionals that such a reduction in access may lead to unintended pregnancies, particularly teenage pregnancies, and undiagnosed sexually transmitted infections. This cannot be compensated for by a few outreach clinic sessions or on-line testing.
9. 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 took over six months for the online testing service that was a major feature of the CNWL “offer” 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. It is known that a number of HIV patients have not found the service at Buryfields Clinic 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.

10. 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.

11. The Select Committee will no doubt be aware of the increasing level of concern about cuts in sexual health services as a result of new commissioning arrangements. Since the Surrey procurement decision was taken in October 2016 there has been a succession of critical reports – from the All-Party Parliamentary Group on HIV/AIDS, the King’s Fund and in August 2017 from Public Health England - about the commissioning of sexual health and HIV services since responsibility for public health passed to local authorities. The Public Health England report noted that decreased investment is widespread with the level of disinvestment ranging from 5% to 25% and a mean average of 14%. The 33% disinvestment imposed by Surrey County Council in its contract for sexual health services was therefore over twice as much as the average level of disinvestment. Similar issues of poor commissioning decisions and severely reduced services were reported at a recent meeting of the APPG that I attended.

Recommendation

12. Sexual health services are a clinical function that are closely linked to HIV, genito-urinary services and other clinical areas such as maternity. Commissioning responsibility and the associated funding should be repatriated to the NHS and where cuts to services have been made, due to centrally imposed reductions in the public health budget, they should be reinstated as far as the clinical provision is concerned. NHS commissioners should engage fully with service users, GPs and other stakeholders on the premise of a service model that co-ordinates community based services, including on-line access to self-testing kits, with specialist integrated hospital provision.

I would be happy to attend the Select Committee with GP and patient colleagues to give evidence direct to the members.

Stephen Fash
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