

# Ad Hoc Panel Report on NHS Brighton & Hove's Procurement of a City GP-Led Health Centre

## 1 Formation of the Ad Hoc Panel

- 1.1 At the 04 March 2009 Health Overview & Scrutiny Committee (HOSC) meeting, HOSC members debated a Public Question concerning the establishment of a Brighton & Hove GP-Led Health Centre.<sup>1</sup>
- 1.2 The topic of the GP-Led Health Centre had been one which HOSC members had addressed on several prior occasions, and it was evident that there was considerable local interest in the issue. Members therefore decided that the subject was one which merited further investigation, and it was agreed that an ad hoc scrutiny panel should be established. Councillors Trevor Alford, Kevin Allen and Jason Kitcat agreed to sit on the Panel, with Councillor Alford elected Chairman.
- 1.3 Panel members subsequently met to scope the topic, agreeing that the initial issue to be determined was whether the process of tendering the GP-Led Health Centre contract (including any requisite public/stakeholder consultation) had been properly conducted by NHS Brighton & Hove. Depending on the results of this investigation, other issues, such as the suitability of the preferred bidder, and broader questions concerning the commercial tender of NHS contracts, might consequently emerge (i.e. particularly so if significant flaws in the tendering process were identified).
- 1.4 Scrutinising a tendering process can be a complicated business, as some elements of tenders may reasonably be subject to commercial confidentiality. It quickly became apparent that relatively little would be achieved by holding public evidence-gathering meetings at an early stage of the scrutiny investigation, as is the norm with ad hoc scrutiny panels, as a very large part of any such meeting would inevitably have to be held in camera due to the commercially sensitive nature of the evidence discussed. Panel members therefore decided that there should be an initial, confidential, meeting with officers of NHS Brighton

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<sup>1</sup> The Public Question, submitted by Mr Ken Kirk, was: "We already know that the B&H PCT (Primary Care Trust) didn't conduct a proper public consultation over the setting up of a GP Clinic, contravening the Department of Health's PCT Procurement Plan. The PCT has given the contract for it to Care UK who run the SOTC (Sussex Orthopaedic Treatment Centre). It was revealed at the November HOSC that the SOTC selects the cheaper surgical procedures, leaving the BSUHT (Brighton & Sussex University Hospitals Trust) to fund the expensive ones. At the meeting a senior clinician stated the hospital has a £2 - £3 million deficit as a result. On whose behalf does B&H PCT spend our NHS funds? Would the committee investigate the awarding of this contract?"

& Hove to discuss in detail the tendering process. Thereafter, meetings in public could be arranged should members identify a need for further investigation.

- 1.5** Officers of NHS Brighton & Hove agreed to meet with the Panel members and a meeting was arranged for 11 May 2009. At this meeting, the Panel discussed the tender of the GP-Led Health Centre contract with Jane Simmons (Head of Partnerships and Engagement, NHS Brighton & Hove), Jonathan Read (Assistant Director of Finance, NHS Brighton & Hove), Steven Ingram (Strategic Commissioner for Primary Care, NHS Brighton & Hove) and Kate Hirst (Project Manager for the GP-Led Health Centre Procurement, NHS Brighton & Hove). Details of this meeting can be found later in this report.

## **2 Background and Disambiguation: GP-Led Health Centres; Additional GP Services for Under-Doctored Areas; and Polyclinics**

### **2.1 GP-Led Health Centres**

- 2.1(a)** The GP-Led Health Centre initiative was launched by Lord Professor Darzi in his national review of the NHS: "High Quality Care For All" (and previously, in more or less identical form, in his interim report: "Our NHS, Our Future"). In High Quality Care For All, Darzi identifies particular problems with GP services. These include:

- 2.1(b) Access.** Darzi contends that there is a major national issue with access to GPs. Access, in this instance, refers not to physical accessibility so much as to surgery opening times. For once, this is not a problem which necessarily correlates with deprivation. In fact, the most deprived people are likely to be unemployed or retired and therefore to have relatively few access problems, as they can attend GP services during normal opening times.

However, access can be a major problem for people working full time, particularly so for commuters; and for tourists, students and anyone else who spends time in a locale where they are not registered with a GP. There is also a much more general issue of access to GP services over the weekend, with few practices open on Saturdays and hardly any on Sundays. (Out of Hours GP services are available, but some have a poor reputation, and they are not always well publicised or widely used.)

- 2.1(c) Registration.** It seems that growing numbers of people are not registering with GPs. Some of these people may be recent immigrants (and possibly non-native speakers of English) who may not fully understand how to access NHS healthcare; others may belong to groups that typically experience problems with the system of registration (homeless people, people with substance misuse issues

etc). Still others may not come from 'deprived' or 'at risk' communities at all: many students and young working people do not bother registering with a GP, perhaps because they do not anticipate requiring primary care services, perhaps because they are unwilling to take the time to pro-actively search out a local GP practice with spare capacity.

Under-registration is a problem for the NHS for several reasons. Firstly, patients who are not registered with a GP may not present for minor treatments. Given that the most effective (and cost-efficient) treatments for many conditions involve early intervention, this can cause difficulties. Secondly, when unregistered patients do present for treatment, they often do so in acute care settings (e.g. A&E). This is relatively expensive and impacts upon the ability of secondary care providers to deliver services for those who are genuinely acutely ill. Thirdly, GPs are increasingly being tasked with providing and collating patient information; clearly this role cannot be properly undertaken if large numbers of people remain unregistered.

**2.1(d)** In order to deal with these problems of access and under-registration the Darzi review required every PCT in England to commission a 'GP-Led Health Centre' (152 nationally). This is defined as an additional GP resource providing services for both registered and unregistered patients. The service must be available 7 days a week, 12 hours a day, and should be situated so as to maximise its benefits in terms of the access and registration criteria. The GP-Led Health Centre should also provide a range of community healthcare services, to be locally determined according to need.

## **2.2 Additional GP Services for Under-Doctored Areas**

**2.2(a)** High Quality Care For All featured another primary care initiative which may sometimes be confused with the GP-Led Health Centre plans. This initiative sought to address the issue of 'under-doctoring'. Since GPs are independent contractors, they have a great deal of freedom in terms of choosing where they operate. In consequence, GP services are not evenly spread across the country. To further complicate matters, GPs tend, on average, to cluster in more wealthy areas, whereas people in the greatest need of primary care services tend to be concentrated in more deprived parts of the country. Darzi addressed this issue by identifying areas of England which were particularly under-doctored and requiring PCTs to develop additional GP services in these areas. No part of Brighton & Hove was considered to be under-doctored under Darzi's criteria, so this initiative has little direct local application.<sup>2</sup>

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<sup>2</sup> The only area to qualify as 'under-doctored' in the South East Coast Strategic Health Authority region was Medway.

## 2.3 Polyclinics

- 2.3(a)** Some time before he embarked on his national review of the NHS, Lord Darzi was commissioned to undertake a review of London healthcare services – Healthcare for London: A Framework for Action.
- 2.3(b)** Healthcare for London differs significantly from High Quality Care For All in that the former is a detailed examination of London’s acute care configuration, while the latter is much more a ‘high level’ survey of the state of the NHS.<sup>3</sup> Although much of the London review is of little obvious relevance outside the capital, one initiative has been widely flagged as having a broader application – this concerns the creation of a network of ‘Polyclinics’.
- 2.3(c)** ‘Polyclinic’ is a term which has been in use for more than a hundred years to describe a variety of primary care facilities. In terms of Darzi’s London review, though, a Polyclinic can be defined as the bringing together of local GP practices<sup>4</sup>, usually (although not necessarily) in a single building.<sup>5</sup> As well as providing GP services, a Polyclinic will typically offer a range of other services, potentially including diagnostics, out-patient appointments, specialist clinics (i.e. for pain-management, sexual health etc.) and minor surgery.<sup>6</sup>
- 2.3(d)** Polyclinics are intended to facilitate the reconfiguration of London’s acute healthcare, which will involve a small number of large hospitals being developed into specialist centres, and the effective downgrading of many of the current smaller acute hospitals (District General Hospitals: DGHs). Polyclinics will re-provide some services which are currently run from these facilities, thereby allowing reconfiguration to take place without impacting upon local levels of service provision.
- 2.3(e)** Polyclinics are also designed to improve access to primary care: the contention is that many London GP practices currently offer rather poor facilities for people with disabilities and can be difficult to reach by public transport. It is also argued that the high number of small practices in the capital and their relative isolation from one another impedes the spread of best practice across the primary care sector.

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<sup>3</sup> High Quality Care For All is itself a fairly high level document, but it is also the impetus for a much more detailed examination of NHS services to be undertaken at a regional (i.e. SHA) level. In the South East Coast SHA region this review is known as “Healthier People, Excellent Care”. (HOSC members have received briefings from the SHA on the content of Healthier People, Excellent Care and will be further involved as the initiative develops.)

<sup>4</sup> GP practices within a polyclinic would be co-sited and might choose to share some costs (of I.T., administrative staff etc.), but would remain as discrete practices sharing a building.

<sup>5</sup> Some polyclinics may be ‘virtual’ – a network/federation of existing GP practices rather than co-siting in a single locality.

<sup>6</sup> Helpfully, under Darzi’s definition, Hove Polyclinic is not a polyclinic as it does not host GP services.

Coalescing small local practices into larger, purpose-built facilities with reasonable transport links is therefore viewed as a solution to these problems of access and the development of best practice.

**2.3(f)** It must be said that the polyclinic initiative has a number of critics, including many London GPs, who rebuff claims that the current configuration offers a poor service. There is also considerable scepticism about the motives behind the initiative, with Darzi's most trenchant opponents viewing the 'centralisation' of GP services as the thin end of a wedge which could end up with the erosion of independent GP practices and their eventual replacement with salaried GPs (working either for the NHS or for large independent sector firms). There are also strenuous objections to the plan to 'localise' London DGH services, particularly from communities who fear the degradation/loss of local acute care.

**2.3(g)** Healthcare for London is a review of the capital's healthcare configuration, and as such, should have only parochial implications. However, the London review has been very widely interpreted as introducing a blueprint for developments across the entire country (an interpretation which has been encouraged by some influential voices within the NHS). There has consequently been a good deal of debate about the desirability of polyclinics, and their suitability for particular parts of the country etc.

**2.3(h)** There has also been a good deal of confusion about what constitutes a polyclinic, sometimes manifested as a conflation of polyclinics, GP-Led Health Centres and additional primary care resources targeted at under-doctored areas.<sup>7</sup>

## **2.4 Disambiguation**

**2.4(a)** It is clear that the Brighton & Hove GP-Led Health Centre cannot reasonably be described as a polyclinic. Firstly, it represents an additional GP resource, not a coalition of existing practices. Secondly, the GP-Led Health Centre will be a standard size GP practice, not the kind of very large practice (or co-sited group of practices) envisaged by Darzi. The GP-Led Health Centre will provide additional services, rather like a polyclinic, but then so do many individual GP practices.

**2.4(b)** Therefore, whatever the merits of the London polyclinic initiative, and whatever intentions there may be to extend the scheme beyond the capital, the Brighton & Hove GP-Led Health Centre is not itself a polyclinic and should not form part of the polyclinic debate.

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<sup>7</sup> For those who take the view that elements of NHS strategic planning are designed to encourage greater provider involvement by the corporate for-profit sector, there may be good reason to conflate polyclinics and GP-Led Health Centres – as both can be viewed as attempts to create structures which are attractive to the corporate healthcare sector (although in the case of polyclinics, any such intention is at a remove from the plans as set out in Healthcare for London).

**2.4(c)** Neither is the GP-Led Health Centre an additional primary care resource targeted at under-doctored areas. Whilst it may plausibly be argued (*pace* Darzi) that some areas of Brighton & Hove are in fact under doctored, it should be clear that the GP-Led Health Centre is not primarily intended to address this issue.<sup>8</sup>

### **3 Concerns About the GP-Led Health Centre Initiative**

**3.1** Some concerns about the GP-Led Health Centre may therefore not be valid. However, other concerns which have been raised locally and nationally may be, and the panel has considered these. These issues include:

**3.1(a) Local Validity of the Initiative.** Although there is no local ability to opt out of this national initiative, it may still be worth asking whether the GP-Led Health Centre scheme is a good way to address issues of access and registration in Brighton & Hove or elsewhere. Certainly, Darzi's plans have been criticised for being imposed on all 152 PCT areas across England, and it can be argued that a 'one size fits all' solution will not suit every locality. This may be particularly the case with large, rural PCT areas with no major population hub. In such areas, a single additional GP facility is unlikely to improve services for very many people, as it will only be local to a minority of residents. The suspicion is that a solution designed for essentially urban problems has been imposed on PCT areas which have very different geographies.

This point may well be valid in terms of the GP-Led Health Centre initiative as a whole, but Brighton & Hove is a compact urban area with very high numbers of tourists, temporary residents (e.g. language students) and commuters. It would therefore seem likely that the initiative is as well-suited to the city as it is to anywhere: it is clear that there is a local need for accessible GP services which is not currently being addressed, and clear also, that a single centrally located facility might adequately address many of these needs.

**3.1(b) Location.** The location of the Brighton & Hove GP-Led Health Centre may be less a matter of debate than the location of, say, the West Sussex equivalent, but it is still an important issue. The central Brighton location chosen (on Queen's Road) does seem a logical option given the remit, as the practice will be readily accessible to everyone using Brighton train station and Brighton city centre. The only obvious alternative would have been a central Hove location, but as Hove has rather fewer tourists and commuters than Brighton, it is easy to see why the Brighton option was preferred.

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<sup>8</sup> Thus there would be no argument for locating the Centre in, say, East Brighton (the city's principle under-doctored area), unless such a location fitted the GP-Led Health Centre criteria (readily accessible by tourists, unregistered patients, commuters etc).

Whilst the location of the health centre may not be a particularly controversial issue, Panel members were interested to determine what steps, if any, NHS Brighton & Hove had taken to gauge local opinion and involve city residents in this issue.

**3.1(c) Large Vs Small.** Some criticisms of the GP-Led Health Centre initiative seem predicated on the belief that contracts for health centres are likely to be awarded to major national/international providers, rather than smaller local concerns.

GP-Led Health Centre contracts are awarded via a competitive tender process. It can be argued that this process is likely to favour large organisations rather than small ones, as the mechanics of application are rather complicated, requiring a great deal of involved form filling – something which is clearly easier for larger organisations to undertake. This may be particularly so in the context of this type of national initiative since some large firms may choose to submit tenders for several different locations across the country and may therefore be able to re-use the generic elements of their tender, whereas bidders interested in only one location have, relatively speaking, a more onerous task.

Of course, there are sound reasons for demanding a high level of engagement on the part of bidders for contracts, as the information gleaned during the tender process can be used to establish the bidder best able to deliver the required level of performance (and because making tenders demanding discourages non-serious bidders from applying). However, there is a point to be answered here, namely was the tender process so complicated that it effectively excluded smaller bidders who might nonetheless have been able to deliver an effective service?

**3.1(d) The Independent Sector.** Many people opposing the GP-Led Health Centre initiative appear motivated by a concern that this initiative will result in an increased independent sector presence in NHS-funded primary health care.

The basis for this type of concern is not always clear, as primary healthcare is already dominated by the independent sector: almost all GPs are partners in (or employed by) GP practices which are independent profit making concerns, structurally identical to any other 'for-profit' business. It is consequently hard to see how this or any other initiative will actually increase independent sector involvement in primary care.

In any case, the NHS is expressly committed to commissioning a 'plurality of providers,' including the for-profit independent sector.<sup>9</sup>

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<sup>9</sup> See 'Delivering the NHS Plan' (2002).

More pertinent here may be the issue of *corporate* independent sector involvement in the primary health market, the argument presumably being that very large firms may not provide the localised/personalised services that people value from traditional GP practices. Therefore, it is necessary to determine whether the successful bidder for the Brighton & Hove GP-Led Health Centre was able to offer assurances that, whatever their status as a company, they were able to offer a localised/personalised service.

**3.1(e) Cost Vs Quality.** Cost is obviously an important and quite legitimate factor in determining the result of any competitive tender. However, there are valid worries that contracts may be awarded to the lowest bidder, even in situations where a more expensive bidder might offer a qualitatively better and more sustainable service which, objectively speaking, would be the better option.

In terms of funding for the GP-Led Health Centre initiative, this comes out of PCT annual allocations rather than being an additional 'ring-fenced' sum.<sup>10</sup> There is therefore a potential PCT interest in encouraging low bids for this type of service. It must however be stressed, that this is a hypothetical risk: the Panel has no evidence whatsoever that NHS Brighton & Hove has ever inappropriately awarded a contract to the lowest bidder and does not suggest that this has ever happened. Nonetheless, any body investigating the award of a contract via competitive tender has a legitimate interest in ascertaining whether cost was appropriately weighted against quality, deliverability etc.

**3.2** Therefore, when it set out to scrutinise the tender for the Brighton & Hove GP-Led Health Centre, the Panel had some questions in mind. These included:

- The degree of consultation regarding the location of the health centre
- Whether the tender process prioritised large firms, when a smaller provider may have been capable of delivering just as good a service
- Whether the tender process took sufficient account of the localised and personalised nature of effective GP services
- Whether the process of awarding the contract appropriately weighted cost against quality, deliverability etc.

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<sup>10</sup> In theory, annual PCT allocations include funding for national in-year initiatives such as GP-Led Health Centres, so there is in fact additional resourcing to pay for the extra GP facilities required. PCTs are not necessarily informed in advance about these initiatives, but are expected to make contingency plans to accommodate such projects when they draw up their annual Business Plans.



## **4 The Brighton & Hove Tender Process**

- 4.1** On 11 May 2009 Panel members met with officers of NHS Brighton & Hove to discuss aspects of the tendering process for the GP-Led Health Centre. This meeting was confidential, as some of the information disclosed might be considered commercially sensitive. In order for the subsequent report to be publicly accessible it has been necessary to omit some of the details discussed at this meeting.
- 4.2** At this meeting, the tender process was explained to Panel members. There are several stages to a competitive public sector tender:
- (i)** In the first instance, the organisation tendering will advertise its intention to contract for a service.
  - (ii)** Potential bidders will respond to this advert, stating that they are interested in applying.
  - (iii)** The tendering organisation will then send out a Pre-Qualification Questionnaire (PQQ). PQQs are intended to sort applicants with a realistic chance of managing the contract from those who lack the requisite experience or financial stability or who are not genuinely committed to progressing.
  - (iv)** Potential bidders who respond to the PQQ will then have the information they have submitted via the PQQ assessed/scored and bidders who exceed the PQQ threshold will be invited to submit bids based on a detailed explanation of the requirements of the contract. This is called an Invitation To Tender (ITT).
  - (v)** These bids will then be scored, and the successful bidder awarded the contract (assuming their bid is of an acceptable quality; if no bid met a threshold of adequacy then the tender process might have to be repeated).
- 4.3** In terms of NHS procurement, the Department of Health provides PCTs with general guidance for conducting tenders. This guidance may then be augmented (as it was in the case of the GP-Led Health Centre initiative) with specific instructions relating to a particular procurement. The guidance determines the basic structure of a procurement process, but there is often considerable scope to fine-tune the details of the tender in order to take account of local conditions. All public sector procurement must accord with European law.
- 4.4** NHS Brighton & Hove procurements are externally overseen by the South East Coast Strategic Health Authority (SHA). The SHA ensures that the tender accords with Department of Health guidance and with European law. Procurements are also internally overseen, both by the

NHS Brighton & Hove Board and by the PCT's Professional Executive Committee (PEC). Procurements must also accord with the NHS Brighton & Hove Internal Standing Orders (which define how the organisation must set about particular tasks). This is overseen by the PCT's Procurement Committee, a sub-committee of the PCT board.

- 4.5** There were twelve expressions of interest from potential bidders at the first stage of the Brighton & Hove GP-Led Health Centre tender. Six were eliminated after PQQ responses were scored. The remaining applicants were invited to tender for the contract; four bids were received, and three evaluated (one bidder withdrew before evaluation).<sup>11</sup> The preferred bidder was then chosen from this shortlist of three.
- 4.6** Panel members were assured that this was a fairly standard rate of attrition for this type of procurement. When a public procurement begins, the contracting organisation will typically release only sketchy details of the nature of the final contract (quite possibly because aspects of the contract are still being finalised). As the procurement progresses, more details will be released, and some potential bidders are likely to withdraw as it becomes clear that the contract is not of interest to them.

In terms of a national initiative such as that for GP-Led Health Centres, it may also be the case that some bidders submit multiple applications, only following through on the areas which interest them most (e.g. areas where there is relatively little competition).

- 4.7** A wide variety of organisations expressed interest in contracting for the Brighton & Hove GP-Led Health Centre, including independent sector 'for-profit' corporations, independent sector 'not for profit' organisations active in the city, regional GP practices and third sector organisations.
- 4.8** Expressions of Interest were not received from local NHS trusts or from city GPs or GP consortia. In the former instance, this may have been because trusts doubted whether their bids would be accepted, due to worries about the 'vertical integration' of primary and acute services.<sup>12</sup> In the latter instance, NHS Brighton & Hove officers speculated that city GP practices may be insufficiently experienced at working in concord with one another to have submitted a consortium

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<sup>11</sup> In this instance it seems that the bidders re-assessed their application, and deciding that it would certainly be rejected at evaluation, chose to withdraw it.

<sup>12</sup> 'Vertical integration', in this context, refers to the same organisation offering primary (GP) and secondary (acute hospital) services to a population. The danger here would be that a vertically integrated provider might be seen to have a perverse incentive to refer patients from primary to secondary care (or at least to its own secondary care facilities rather than others in the local area), as it would be in its financial interest to do so in terms of the way in which NHS services are paid for.

bid.<sup>13</sup> This may change in the relatively near future, as recent developments in Practice Based Commissioning Groups<sup>14</sup> and in the creation of the Brighton Integrated Care Service (BICS)<sup>15</sup> should serve to create a platform from which city GP practices can join together to bid for contracts.

**4.9** Although Panel members were disappointed that there had been no bid from local GPs, they were assured that NHS Brighton & Hove had done all it properly could to encourage the local primary care sector to take an interest in the GP-Led Health Centre contract.<sup>16</sup>

**4.10** Panel members were concerned that the complexity of the tender process may have deterred smaller local providers from bidding. Officers of NHS Brighton & Hove explained that they had done all they could to make the process accessible, including offering workshops for potential bidders. However, there may be a balance to be struck here. On the one hand it is probably true that extremely complex and onerous tender applications do discourage smaller bidders; on the other hand, complex tenders are not necessarily gratuitously so: detailed tender applications require bidders to show that they have thought hard about the contract, and are likely to flag potential problems or misunderstandings at an early stage, rather than risking them coming to light once the contract has been signed.

**4.11** In the case of the GP-Led Health Centre tender, NHS Brighton & Hove sought to create a contract with a large number of binding performance targets. This contract has been directly developed from information gleaned during the tendering process (in essence the contract is a reiteration of the PQQ and ITT details). There is a clear utility to such a procedure, since it enables the PCT to guarantee performance against the contract rather than trusting the winning bidder to deliver its

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<sup>13</sup> The GP-Led Health Centre contract is not a particularly large one, and would not necessarily be beyond the scope of a single GP practice. However, it was widely anticipated that GP practice interest would generally take the form of consortium bids.

<sup>14</sup> Practice Based Commissioning (PBC) is an NHS initiative which encourages GPs to commission some services for their patients directly (rather than having these services commissioned on their behalf by the local PCT). In practice, most GP practices are too small to commission for themselves, and PBC is therefore undertaken via PBC groups/clusters (e.g. groups of local GP practices commissioning jointly).

<sup>15</sup> BICS has been set up in response to another NHS initiative: 'Choose and Book'. Choose and Book allows patients (via their GPs) to decide which secondary care facility they wish to be treated at, when they want to be treated, and (to some degree) the consultants they want to treat them. However, individual GPs are not always in the best position to advise patients on the options they should pursue, as they may not personally be experts on a particular pathway, although some local GP almost certainly is. BICS is intended to remedy this problem by bringing together city GPs' expertise via a referral service which can ensure that patients are directed to the best available acute providers for their circumstances.

<sup>16</sup> Organisations awarding contracts via competitive tender must not improperly favour one bidder over another. For instance, they must ensure that information or guidance offered to one bidder is also offered to all other applicants.

promises. This degree of control is well beyond that which PCTs are able to exercise on the majority of their GP contracts (General Medical Services Contracts) which do not generally permit the imposition of local performance indicators. Therefore, the complexity of tender information is, in this instance, directly related to assuring that the successful bidder is both capable of delivering a good service and contractually bound to doing so.

- 4.12** However, even though the complexity of tenders may be entirely functional, it is still the case that they will generally tend to favour larger providers. This seems to a degree unavoidable, although NHS Brighton & Hove officers did suggest that, whilst this may be the case for individual tenders, it can become less so over a period of time, as bidders for local contracts become more experienced at going through the tender process, which is essentially very similar for a range of procurements. Thus, providers who bid for several contracts and who take the opportunity to receive detailed PCT feedback on their failed bids, are typically able to make significant improvements to their applications for subsequent contracts. Officers of NHS Brighton & Hove told Panel members that some local healthcare providers who had initially had little success in competitive tenders were now regularly competing effectively and winning contracts. Thus, although the competitive tender process may favour the corporate sector in any single instance, there is nothing to stop smaller firms from developing into effective bidders over time, providing they are willing to commit resources to doing so.

## **5 Scoring the Tender**

- 5.1** At the ITT stage, applicants were judged against a series of criteria, which can be summed up thematically as:

- **performance** (the quality of services to be provided)
- **cost** (the sum charged to provide these services)
- **risk** (the risk of the bidder being unable to deliver the contract)
- **timing** (how quickly the provider can get its service operational).

An overall **Value For Money** (vfm) score was also calculated for each bidder (essentially this was reached by dividing each bidder's performance score by their costings).

- 5.2** All bidders were required to exceed a threshold for performance before being evaluated against other criteria.
- 5.3** There was no specific test of local experience at either the PQQ or ITT (the formal invitation to tender) stages of the procurement. Attaching such conditions would have been difficult, as it might have effectively limited bidders to those organisations currently active in the Local Health Economy. Such a limitation might have been legally

problematic, and would certainly have run counter to NHS Brighton & Hove's stated aim to encourage a 'plurality' of local providers (i.e. a greater plurality than is currently the case). However, although bidders were not asked to show local experience, they were required to demonstrate a proven ability to work with local providers and to align their practices with the needs of the locality. This seems to have been the most that could have been demanded in the circumstances.

- 5.4** The tender process is essentially one in which bidders self-evaluate their ability to perform against the demands of the contract. There is therefore a quite reasonable worry that unethical bidders might exaggerate their competencies in order to win contracts. However, in terms of the GP-Led Health Centre tender, many of the performance guarantees which bidders must make will subsequently be embedded in their contract, meaning that applicants will be required to deliver on their promises. Bidders who fail to deliver in accordance with their contractual obligations can be replaced at any point before the Centre becomes operative, and may be liable for damages. An underperforming service will also incur financial penalties and may be terminated. In this instance, therefore, it does seem as if a good deal has been done to incentivise applicants to supply accurate information.

## **6 Invitation To Tender (ITT) and Final Stage Evaluation**

- 6.1** Six potential bidders who submitted PQQs were issued an 'Invitation To Tender' (i.e. they were invited to submit formal bids). Of these, four organisations placed bids, and three formed the final shortlist for evaluation.
- 6.2** The successful bidder, **Care UK**, is a large for-profit organisation operating a number of healthcare facilities nationally, including the Sussex Orthopaedic Treatment Centre (SOTC). The two other short-listed bids came from a not-for-profit independent sector provider in alliance with a local GP practice, and from a non-local GP practice. Since the identity of and details concerning unsuccessful bidders might be deemed commercially confidential, these organisations will be referred to as **bidder B** and **bidder C** (with Care UK **bidder A**).
- 6.3** After evaluation of the formal bids, it was established that all three short-listed bidders had comparable performance scores.<sup>17</sup>
- 6.4** However, bidder A offered to contract for the GP-Led Health Centre for considerably less than bidders B and C. This difference in cost amounted to approximately £2,000,000 over the course of the 5 year

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<sup>17</sup> The GP-Led Health Centre contract will measure performance via a series of performance indicators/targets. Up to 25% of the funding for the contract may be withheld for under-performance.

contract (i.e. bidder A was £2 million cheaper than the next cheapest bidder). Bidders B and C submitted very similar costings.

- 6.5** Given the large discrepancy between bidder A and the other bidders' costings, and given that bidders B and C submitted very similar tenders in terms of price, Panel members were concerned that bidder A's costing might prove to be an underestimate. PCT officers told members that they were confident that bidder A's figures were robust as Care UK has some experience of running similar centres, and should consequently be in a good position to estimate costs. In any case, there is relatively little risk for the Local Health Economy here, as Care UK is bound to deliver its contract at the price agreed; it will apparently not be the case that extra money will be provided to top up an unrealistically low bid.<sup>18</sup>
- 6.6** Prior to beginning this tender process, officers of NHS Brighton & Hove met informally with regional PCT colleagues and with officers from the Department of Health to try and estimate a reasonable price (or range of price parameters) for the GP-Led Health Centre contract. All three of the short-listed Brighton & Hove tenders came within these anticipated parameters (with bid A at the low end and bids B and C at the high end of the parameters). There is therefore no reason to suppose that the winning bid is undeliverable, as it falls within the range of anticipated pricings. (NHS Brighton & Hove officers noted that had the bid been outside the expected parameters it might well have caused them concern.)
- 6.7** Panel members asked how bidder A's tender came to be lower than those of the other bidders. There appear to be three elements to this:
- (i) Staffing.** Bid A specifies that the GP-Led Health Centre GPs should be permanent, salaried GPs, whilst bids B and C rely upon employing local GPs to work part-time as locums. Generally speaking, it is considerably cheaper to employ permanent staff rather than locums (as locum rates of pay are higher).<sup>19</sup>

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<sup>18</sup> The only real opportunity for Care UK to be paid more than the contracted amount for running the GP-Led Health Centre would be if there was significant over-performance against the contract (i.e. more patients were seen than had been contracted for). This is not anticipated, and, if it did occur would probably indicate a previously unmet level of need in the local health economy.

<sup>19</sup> 'Continuity of Care' (i.e. enabling patients to see the same doctor whenever they access GP services) is often viewed as a key aspect of GP services, particularly for patients with long term conditions. However, this did not form part of the GP-Led Health Centre tender requirements (and would have been very difficult to impose, as GPs are statutorily entitled to choose to work part time, take maternity leave or otherwise work in ways which impact upon their ability to deliver continuity of care, whatever agreement their employers might have with the local PCT). To the degree that continuity is a concern though, the bidder A model of permanent salaried staff would seem better placed to provide it than the bidder B and bidder C models of employing locums from local GP practices.

- (ii) **GP/Nurse Ratio.** Bid A specifies a rather lower GP to Practice Nurse ratio than bids B and C (i.e. more nurses and fewer doctors) across the term of the contract. This has a significant impact upon costs, as Practice Nurses are considerably cheaper to employ than GPs.<sup>20</sup>
  - (iii) **'Back Office' Costs.** As Care UK is a large enterprise it may be able to use its existing resources to supply certain 'back office' services (general admin, HR, ICT support etc.) more cheaply than can other bidders.
- 6.8** In terms of the other areas of the tender evaluation (risk, deliverability etc.), all the short-listed bidders were able to satisfy these criteria. Generally speaking, these were pass/fail issues (e.g. an organisation is either deemed to be financially stable or it isn't) rather than areas where there would be very much value in rating bidders against each other.
- 6.9** Panel members enquired how reputational issues were assessed in the evaluation process. This is a pertinent question, since Care UK has a somewhat chequered reputation as a healthcare provider, both locally (at the Sussex Orthopaedic Treatment Centre) and nationally. Members were told that both the PQQ and ITT processes included mechanisms to examine the past performance of bidders. The evaluation of Care UK's bid (and of bids B and C) concluded that there was no reason to reject these bids because of problems which may have occurred elsewhere.

## **7 Recommendations**

- 7.1** GP services are a key component of the British healthcare system, acting as the 'gatekeeper' to all other services. It is therefore vital that everyone has ready access to a GP. At the moment it is evident that this is not always the case. People who work long hours, who commute, or who are temporarily living and/or working away from home may struggle to access a GP, as may many people who live unsettled or chaotic lifestyles.

People who are not registered with a GP or who are unable to attend their GP practice during its opening hours may find that they are effectively denied early diagnosis of and treatment for a range of conditions. When such people do access healthcare, it is often at 'inappropriate' points in the system, such as hospital A&E departments.

It is therefore clear that there is room for an initiative which provides GP services for unregistered patients and for those not well served by their own GPs.

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<sup>20</sup> NHS Brighton & Hove claims that it has carefully checked this skill-mix and is confident that it can deliver high quality services.

The GP-Led Health Centre initiative may well not be the best solution for many localities, and its blanket introduction across England is scarcely a shining example of devolved decision making. However, in the context of Brighton & Hove - a compact urban area with very large numbers of commuters, temporary residents and visitors - the establishment of a city-centre primary care facility offering walk-in services to registered and non-registered patients has an obvious utility.

- 7.2** It is also evident that, given the significant cost differences between the short-listed bidders for the Health Centre contract, and the fact that all bidders were of broadly comparable quality and met the other tender criteria, NHS Brighton & Hove had little choice other than to award the GP-Led Health Centre contract to Care UK, as this was clearly the most competitive of the short-listed bids.
- 7.3** Therefore, in terms of the substantive issue this Panel was formed to investigate, it is quite clear that NHS Brighton & Hove acted properly in procuring a GP-Led Health Centre and in contracting Care UK to run the Brighton & Hove facility. The Panel found no reason to suppose that NHS Brighton & Hove did anything other than to adopt best practice throughout the procurement.
- 7.4** The above notwithstanding, there are still aspects of the GP-Led Health Centre initiative and the procurement of a local contractor which remain of concern to Panel members. These include the points listed below.
- 7.5** **Reputational Issues.** It can certainly be argued that Care UK has a poor reputation as a healthcare provider. This is the case nationally, where fairly intense recent media coverage has focused on two Care UK services which have been alleged to be sub-standard. It is also the case locally, where there have been long standing problems with the management of the Sussex Orthopaedic Treatment Centre (SOTC), culminating in a highly critical Healthcare Commission report on the centre.<sup>21</sup>

However, even assuming that all the media allegations against Care UK are well founded (which may well not be the case), this is a complex issue. It is quite possible for an organisation (perhaps particularly if it is a large corporate entity operating very widely) to run some services or types of service very poorly and others very well. Therefore, the fact that a large provider has encountered significant problems with one or more of its operations does not necessarily mean

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<sup>21</sup> The SOTC was originally managed by Mercury Health, with Care UK taking over a contract which had already run into trouble. All the problems at the SOTC may therefore not be the fault of Care UK. However, Care UK has now been managing the facility for some time and, at least at the point of the Healthcare Commission investigations, had not instituted necessary and widely flagged reforms to service.



that it is unfit to run other services (although clearly this is not an irrelevance: one would generally rather be dealing with an organisation which delivered consistently high quality than one whose quality was patchy).

In the case of the GP-Led Health Centre, Panel members were assured that Care UK's reputational issues had been taken into account as part of the tender process, and had not been deemed serious enough to disqualify the bidder.

It is also the case that the GP-Led Health Centre contract has been designed so that it contains many enforceable performance targets. This should ensure that the services provided are those contracted.

The Panel welcomes these assurances from NHS Brighton & Hove and trusts that the Health Centre will be a success. Nonetheless, members still have reservations about Care UK's ability to deliver the quality of care required. Given these doubts, the Panel urges NHS Brighton & Hove to monitor the establishment of the GP-Led Health Centre very closely to ensure that Care UK does in fact deliver the high level of service it is contracted to provide.

**7.5(a) The Panel recommends that NHS Brighton & Hove pays particular attention to monitoring the GP-Led Health Centre contract, given Care UK's uneven record as a provider of high quality healthcare.**

**7.6 Awarding NHS Contracts Via Competitive Tender.** Clearly it is national NHS policy to award contracts via competitive tender and not something that can be influenced at a local level. Nonetheless, Panel members feel there is value in noting that they have reservations about the general process of competitive tendering for NHS contracts.

The problem here is that the competitive tendering process inevitably favours larger organisations which can afford the time and effort required to produce the high quality documentation required for a successful tender bid. These organisations will not necessarily be from the corporate 'for-profit' sector (NHS trusts are often quite large enough to compete with the corporate sector in this respect), but they are unlikely to be small businesses and may well not be firms with local connections or histories.

One way in which this might be mitigated would be for local PCTs to work effectively to encourage a wide range of local providers to gain expertise in bidding for NHS contracts, and to facilitate the development of consortia of providers in order to bid for contracts beyond the scope of sole businesses. As already noted, even relatively small organisations can be effective bidders for tenders providing they develop some expertise in the tendering process – an expertise which is best gained by bidding, receiving detailed feedback and then bidding again for subsequent contracts.

Developing providers in the local health economy in this type of way would be directly beneficial to the city as it would help to make local businesses more competitive against national and international competition. Given that competitive tendering for NHS contracts seems to be here to stay, this may be the best way to mitigate its negative effects on the local health economy.

Officers of NHS Brighton & Hove noted that one of the main learning points they have taken from the GP-Led Health Centre tender has been the need for them to develop the local provider market, particularly in terms of encouraging greater involvement from the city NHS trusts in this type of bid.

Of course, NHS Brighton & Hove has already done a good deal of work in this area, and some earlier initiatives (such as working closely with local GP practices to develop BICS) may already be bearing fruit in terms of the increased competitiveness of local healthcare providers. The Panel trusts that NHS Brighton & Hove will be able to build upon this good work, and that it will keep the HOSC updated on this important issue.

**7.6(a) The Panel recommends that HOSC should request a report from NHS Brighton & Hove on its strategy to improve the commercial competitiveness of local health care providers.**

**7.7 Monitoring the GP-Led Health Centre.** GP practices are routinely audited for the quality of their services, both by the Quality Care Commission<sup>22</sup> and by local PCTs. In time it would seem reasonable to assume that the GP-Led Health Centre will be monitored in the same way. However, given the importance of this initiative, its estimable aim of improving access to primary care, and the controversial performance history of Care UK, it is evident that special measures must be put in place for monitoring the early progress of this contract.

The Panel is particularly interested in ascertaining the following information:

- Whether the Health Centre is running smoothly from a contractual perspective (i.e. whether all aspects of the management contract have been adhered to)?
- Whether there has been significant under or over-performance (i.e. more or fewer patients than anticipated)?
- What percentage of service users are registered/unregistered patients (and whether they are city residents, visitors etc)?

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<sup>22</sup> Until recently this role was undertaken by the Healthcare Commission.

- Whether the Health Centre's activity is in line with a 'typical' city GP surgery (e.g. is the Centre seeing an atypical number of people with particular conditions; are Health Centre GPs prescribing in any interesting ways etc)?
- Whether the GP-Led Health Centre has had an impact upon other city centre GP practices - i.e. have local practice list sizes reduced following the opening of the Health Centre? (Such an impact might not necessarily be detrimental to the Local Health Economy, given relatively high GP list sizes across the city.)
- Whether the additional services (sexual health services) provided at the GP-Led Health Centre have proved popular?
- What impact the Centre has had on (inappropriate) A&E attendances.
- Information on patient satisfaction with the GP-Led Health Centre.

**7.7(a) The Panel recommends that HOSC requests a comprehensive update on the above issues, to be received after the GP-Led Health Centre has been in operation for twelve months or so.**

**7.8 Public Involvement.** One of the issues the Panel was interested in was the degree to which local people had been involved in determining elements of the local GP-Led Health Centre programme. As detailed above, it is clear that, given the requirements of the GP-Led Health Centre initiative, there was relatively little opportunity to involve members of the public in this project.

However, NHS Brighton & Hove did make an effort to involve members of the public in the procurement process, particularly in terms of scoring the various applicants at PQQ stage. The PCT is eager to repeat this with other procurements, and may seek to train a pool of patients for this purpose. The Panel would welcome development of the PCT's policies in this regard as an excellent way of ensuring that NHS procurements are viewed as fair is to ensure that the public are involved in them.

A related issue concerns the degree to which NHS procurements are open to scrutiny by local people and by stakeholders. Panel members appreciate the co-operation of NHS Brighton & Hove in researching and compiling this report and are pleased that the PCT felt able to disclose details of the GP-Led Health Centre procurement to the Panel. However, this disclosure was in confidential session, and it has not been possible to include certain details of this discussion in this report.

To a degree this is wholly reasonable: there is a legitimate argument in favour of commercial confidentiality where the disclosure of information might embarrass an organisation who had placed an unsuccessful bid, or might have a detrimental impact upon the success or costings of

future bids. However, there is room for interpretation here: not all information obtained via commercial tender is necessarily commercially sensitive, and a refusal to disclose any information is likely to fuel public suspicions of wrongdoing whether these are grounded or not.

It is therefore important that PCTs are as open as possible in terms of commercial procurements. The method chosen in this instance – confidential disclosure to HOSC members – is a useful one, but serious consideration should also be given to the full public disclosure of any information that is not truly commercially confidential.

**7.8(a) The Panel commends NHS Brighton & Hove for its constructive approach to sharing information in relation to the GP-Led Health Centre. It is to be hoped that the PCT will be similarly open in terms of other procurements, and will endeavour to place as much information about tenders as possible in the public domain.**

**7.9 Consultation.** There is also a broader issue of public consultation to be considered here, as one of the principle aims of the Panel was to determine whether there had been adequate consultation over the Health Centre initiative.

NHS Brighton & Hove did consult over the development of a city GP-Led Health Centre. It did so by contacting 1500 members of the local Citizens' Panel, asking them where they would prefer a Health Centre to be sited and what additional services they would like to see it provide. The results of this consultation exercise were subsequently presented to the HOSC.

There is obvious merit in this course of action, as the Citizen's Panel is designed to provide a representative cross-section of the local public. It is unlikely that alternative means of consultation would have been successful in engaging a genuine cross-section of local opinion, as public consultations, when they attract anyone at all, tend to attract campaigners and others with strong opinions about a particular initiative. These people may have extremely cogent points to make, but they are unlikely to be 'typical' members of the public or represent an average viewpoint.

There is also an issue of cost to be considered here, as arranging a major consultation exercise with leafleting, public meetings etc. can be very expensive indeed. In this instance, it does not seem that such expense could have been justified.

However, without some form of public engagement where people with strong opinions are given the chance to present their views, the NHS does risk the accusation that it is seeking to avoid or forestall legitimate debate. Relatively simple and economic ways of eliciting public opinion do exist – for example setting up an on-line consultation on the NHS Brighton & Hove website, or running an article inviting comments in the

City News magazine. Such actions might not be appropriate for a very major public consultation exercise, but for an initiative such as this they might provide a useful way for members of the public to have their views taken into account.

**7.9(a) When it launches future initiatives, NHS Brighton & Hove should give serious consideration to ensuring that there is a method via which members of the public can present their views, even in situations where full public consultation would not be appropriate.**

