Brighton & Hove City Council

Overview & Scrutiny

Title:	**HEALTH OVERVIEW & SCRUTINY COMMITTEE**
Date:	**08 JULY 2009**
Time:	**4PM**
Venue	**THE COUNCIL CHAMBER, HOVE TOWN HALL**
Members:	**Councillors:** Peltzer Dunn (Chairman), Alford, Allen (Deputy Chairman), Barnett, Harmer-Strange, Hawkes, Kitcat, Rufus **Co-optees:** Jack Hazelgrove (Older People's Council), Robert Brown (Brighton & Hove LINk)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

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AGENDA

Part One **Page**

1. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

2. MINUTES OF THE PREVIOUS MEETING **3 - 10**

Draft minutes of the meeting held on 20 May 2009 (copy attached).

3. CHAIRMAN'S COMMUNICATIONS **11 - 14**

Following recent media reports on breast cancer screening in the city, Councillor Peltzer Dunn sent letters to the Chairmen of NHS Brighton & Hove and Brighton & Sussex University Hospitals Trust (respectively the commissioners and providers of city breast cancer screening services) asking for more information on city services. Councillor Peltzer Dunn's letters and the NHS trust responses are attached for information.

4. PUBLIC QUESTIONS

A Public Question has been received for this meeting. It is:

"Recent developments in the local health service have shown that the PCTs are being asked to consider non-NHS providers when contracts are allocated. Does the committee agree that, as with the government's recommended procedure, it is vital that the public's views are sought, and would the committee therefore write to all PCTs to ask that a proper public consultation is carried out, to include requesting submissions from Brighton and Hove residents, and the holding of a public meeting, before the allocation of the contract?"

Ken Kirk

5. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received.

6. WRITTEN QUESTIONS FROM COUNCILLORS

A letter from Councillor Rufus has been received.

Breast Cancer Screening

In light of recent figures showing that just 8 per cent of women in Brighton and Hove and East Sussex were seen within 36 months of their last routine breast cancer screening between January and March this year (some 79 per cent below that of neighbouring West Sussex screening service), can the PCT:

- detail what steps are being taken to ensure this situation improves

- detail what, if any, adverse health consequences there may be for women waiting this long for routine screening?"

7. RE-PROVISION OF HEALTHCARE SERVICES IN COMMUNITY SETTINGS **15 - 36**

Report of the Acting Director of Strategy and Governance (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards;*

8. REVISION OF THE CITY WORKING AGE MENTAL HEALTH COMMISSIONING STRATEGY **37 - 44**

Report of the Acting Director of Strategy and Governance (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards;*

9. AD HOC SCRUTINY PANEL REVIEW OF THE BRIGHTON & HOVE GP-LED HEALTH CENTRE **45 - 70**

Report of the HOSC ad hoc scrutiny panel (to follow).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards;*

10. PROVIDERS IN THE LOCAL HEALTH ECONOMY **71 - 74**

Report of the Acting Director of Strategy and Governance (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards;*

11. HEALTH OVERVIEW & SCRUTINY COMMITTEE (HOSC) WORK PROGRAMME

Update on the 2009-2010 Work Programme (to follow).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*

12. CARE QUALITY COMMISSION: REPORT FOR INFORMATION ON CHANGES TO THE QUALITY ASSURANCE REGIME FOR HEALTH AND SOCIAL CARE

Verbal presentation by officers of NHS Brighton & Hove.

13. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

To consider items to be submitted to the next available Cabinet or Cabinet Member meeting.

14. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the 16 July 2009 Council meeting for information.

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fifth working day before the meeting.

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Giles Rossington, 01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication – 30 June 2009

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Commitee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and

(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:

(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].

(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

AGENDA ITEM 2

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4:OOPM 20 MAY 2009

BANQUETING SUITE, HOVE TOWN HALL

MINUTES

Present: Councillors Peltzer Dunn (Chairman), Alford, Harmer-Strange, Hawkes, Kitcat, Marsh, Rufus

Co-opted Members: Robert Brown (Brighton & Hove Local Involvement Network)

PART ONE

96. PROCEDURAL BUSINESS

96A Declarations of Substitutes

96.1 Councillor Mo Marsh announced that she was attending as substitute for Councillor Kevin Allen.

96.2 Apologies were received from Darren Grayson, Chief Executive of NHS Brighton & Hove.

96B Declarations of Interest

96.3 Councillor Marsh declared a prejudicial interest in agenda item 104: South Downs Health NHS Trust – Integration with West Sussex Community Services.

96C Declarations of Party Whip

96.4 There were none.

96D Exclusion of Press and Public

96.5 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if

members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

96.6 **RESOLVED** – That the Press and Public be not excluded from the meeting.

97. MINUTES OF THE PREVIOUS MEETING

97.1 Councillor Kitcat informed members that, following the last HOSC meeting, he had been in contact with Duane Passman, 3T Programme Director for Brighton & Sussex University Hospitals Trust, to request the additional information referenced in the draft minutes to the 22 April 2009 meeting. Councillor Kitcat had not yet received this material, but had been assured of its imminent arrival.

97.2 **RESOLVED** – That the minutes of the meeting held on 22 April 2009 be approved and signed by the Chairman.

98. CHAIRMAN'S COMMUNICATIONS

98.1 There were none.

99. PUBLIC QUESTIONS

99.1 There were none.

100. COUNCILLOR QUESTIONS

100.1 There were none.

101. NOTICES OF MOTION REFERRED FROM COUNCIL

101.1 No Notices of Motion were referred.

102. SUSSEX PARTNERSHIP FOUNDATION TRUST: UPDATE

102.1 This item was introduced by Richard Ford, Executive Commercial Director, the Sussex Partnership NHS Foundation Trust.

102.2 Mr Ford informed committee members of some recent and other planned developments at the trust. These included:

- **Improving Access to Psychological Therapies.** This initiative, with additional funding support from NHS Brighton & Hove, is progressing well. The project has a particular focus on enabling people with mental health problems to stay in employment, and this is likely to be especially important given the current economic climate.

- **Accommodation Services.** Sussex Partnership is reviewing its housing support provision, particularly in light of recent cuts to national Supporting People grants and the increased national and local emphasis on personalisation of care. The trust is aiming to improve its housing services, particularly in the contexts of clients with a dual Diagnosis and of intermediate housing.

- **Mill View Hospital.** Funding for the next stage in the upgrade of Mill View hospital has been approved by the trust board. This will allow Sussex Partnership to improve facilities on the site, including providing a more secure perimeter fence and proceeding as planned with the creation of a 'Section 136' facility (to assess the needs of people detained by the police under Section 136 of the Mental Health Act).

- **Nevill Hospital.** Sussex Partnership plans to close the Nevill hospital, and will need to re-provide the 15 dementia beds currently situated at the Nevill (beds for older people with functional mental health problems will be re-provide at Mill View). However, the trust may choose not to re-provide these beds within Brighton & Hove. Sussex Partnership will come back to the HOSC to discuss this service once more detailed plans have been developed.

- **Secure and Forensic Services.** Currently, a number of secure and forensic mental health services are unavailable within Sussex, meaning that patients have to be treated out of the county. Sussex Partnership is developing services which will allow for the repatriation of many of these beds to sites within Sussex (although not to Brighton & Hove).

- **Children and Young People's Services.** Chalk Hill hospital, a superb new mental health facility for young people, was recently opened in Hayward's Heath. HOSC members (and potentially other interested Councillors) have been invited to tour this and other local acute mental health facilities.

- **Substance Misuse Services.** Sussex Partnership are pleased to have been re-commissioned to provide these services for Brighton & Hove and are seeking to expand some alcohol-related services.

- **Dementia.** City services have to be improved, with particular reference to the personalisation agenda, to ensuring more effective diagnosis of dementia at an early stage, better co-working with other agencies and improved end of life care.

- **Foundation Trust and Teaching Trust status.** Becoming a teaching trust has been particularly valuable in terms of Sussex Partnership's ability to recruit new staff.

102.3 In response to a question regarding plans to re-locate the trust's headquarters, Mr Ford informed members that plans to move from Swandean to the Mill View hospital site had been put on hold, as the

trust's priorities were to improve front-line services (and also because the sale of the Swandean site in the current economic climate was unlikely to be straightforward).

102.4 In reply to queries about the closure of the Nevill hospital, members were told that any re-siting of acute older people's dementia beds outside the city would have to meet two criteria: that the new service improved on current services, and that there was excellent transport provision to and from the new site.

102.5 In answer to questions regarding the likely impact of a recession upon local mental health services, the Committee was told that more people would be expected to present with mental health issues during a recession. However, the trust was well placed to deal with this, having already significantly improved access to psychological therapies (e.g. the services which are likely to be most in demand by people presenting with depression/anxiety).

102.6 In response to a query about the soon to be formed Scrutiny Select Committee on dementia, Mr Ford told members that he welcomed this piece of work and that Sussex Partnership would engage fully with it.

102.7 In answer to questions concerning alternative accommodation for older people with functional mental health problems following the closure of the Nevill, members were told that it should prove possible to accommodate these patients at Mill View, although there would need to be robust planning to ensure that these vulnerable people were not placed at risk.

103. RE-PROVISION OF HEALTHCARE SERVICES IN COMMUNITY SETTINGS

103.1 The Chairman decided that this item should be deferred until the 08 July HOSC meeting.

104. SOUTH DOWNS HEALTH NHS TRUST: INTEGRATION WITH WEST SUSSEX COMMUNITY SERVICES

104.1 John O'Sullivan, interim Chief Executive of South Downs Health NHS Trust (SDH) gave a presentation and answered members' questions on this issue.

104.2 Mr O'Sullivan told members that:

- Integration with West Sussex Health (i.e. West Sussex NHS community services) had come about because the Government had encouraged Primary Care Trusts (PCTs) to divest themselves of provider services so that they could focus on the 'World Class Commissioning' agenda. West Sussex PCT had considered a variety of new homes for its provider services, but had eventually opted for

integration with SDH. (This is an 'integration' rather than a merger, as in the context of NHS trusts, mergers can only occur between two or more statutory bodies; West Sussex Health is not a statutory body.)

- The first formal step in this process of integration is to develop a Management Contract, but this is by no means the end of the process: involved work will be needed over the next two years if integration is to be successful.

- It will also be necessary for West Sussex PCT to develop a commissioning strategy for West Sussex community services, as it must be able to demonstrate that it is committed to commissioning the best value and quality services available (i.e. it cannot simply commission the integrated SDH/West Sussex Health).

- The regional NHS cooperation and competition panel will almost certainly also want to examine the integration to ascertain that it does not impact upon local competitiveness.

- At a later point in the integration process it will also be necessary for SDH to work closely with NHS Brighton & Hove to ensure that the new organisation is able to operate in line with Brighton & Hove commissioning intentions.

- All West Sussex Health staff will second to SDH at the beginning of the integration process.

- East Sussex PCTs have expressed interest in integrating their community services with SDH and this idea is currently being explored.

104.3 In reply to a question about ensuring that the integrated trust focuses on local needs, members were told that SDH has a Service Level Agreement with NHS Brighton & Hove (and West Sussex Health a similar agreement with West Sussex PCT). This sets out levels of services which must be maintained by any integrated organisation.

104.4 In answer to a question concerning user involvement in the integration programme board, the Committee was informed that there was currently no such involvement as work was at a very technical stage. Users would be extensively involved at a stage when their input would be of greater value.

104.5 In response to a question about efficiency savings, members learnt that both SDH and West Sussex Health were committed to making significant efficiency savings and that integration might make this easier (e.g. via combining services such as ICT/administrative support). However, integration was not fundamentally driven by the opportunity to make this type of saving.

104.6 Mr O'Sullivan told members that an estimated £2 million per annum might be saved via integration. This would probably be reasonably proportionate across Brighton & Hove and West Sussex services.

104.7 In answer to a query about TUPE ('Transfer of Undertakings (Protection of Employment) Regulations 1981'), members were told that this should not pose too much of a problem, as all staff to be integrated are current NHS employees and employed on very similar contracts.

105. AD HOC PANEL ON THE BRIGHTON & HOVE GP-LED HEALTH CENTRE

105.1 Councillor Trevor Alford introduced this item, informing members that the ad hoc panel had held a meeting with officers of NHS Brighton & Hove to discuss the tender for the city GP-Led Health Centre contract.

105.2 Following this, the panel members had decided that there was no need for further meetings, although elements of the tender process were worthy of comment. A report on this issue is currently being prepared and will be presented to the Committee at its 08 July 2009 meeting.

106. HOSC WORK PROGRAMME 2008-2009

106.1 Members discussed the HOSC work programme for 2009/2010. Outstanding items which will need to feature in the work programme include: the ad hoc panel report on the GP-Led Health Centre, a report on provider organisations working in the local health economy, and a report on acute care re-provided in community/primary settings (deferred from the 20 May 2009 meeting).

106.2 The HOSC has also committed to receiving updates on the Sussex Orthopaedic Treatment Centre, the Brighton & Hove Local Involvement Network, city dentistry services, the '3T' development of the Royal Sussex County Hospital and the GP-Led Health Centre (i.e. a report on the operational success of the Centre after it has been running for a period of time).

106.3 Members also suggested instituting an ad hoc panel to investigate aspects of the public health agenda (it had formerly been agreed to set such a panel up, but the idea remains at a nascent stage of development).

106.4 A member also proposed that HOSC should examine the issue of immunisation (with particular reference to the prevalence of measles in the city and what, if any, relationship this bore to uptake of the 'MMR' jab).

107. REPORT OF THE DUAL DIAGNOSIS SCRUTINY PANEL

107.1 This item was introduced by Councillor Hawkes, who told members that key issues were the provision of appropriate supported housing and ensuring that services adequately addressed the needs of women and children.

107.2 Richard Ford, Executive Commercial Director at the Sussex Partnership NHS Foundation Trust (SPT), welcomed the report and told members that SPT was actively considering the Panel recommendations.

107.3 In answer to a question about the availability of residential mental health facilities for mothers and children, Mr Ford informed members that there was no such provision within the city, although independent sector services were commissioned on behalf of city residents.

108. ITEMS TO BE REFERRED TO CABINET

108.1 The Committee discussed referring Item 102: Sussex Partnership Foundation Trust – Update to the Cabinet Member for Health and Social Care for information.

108.2 Of particular concern to members were plans to close the Nevill Hospital and (potentially) to re-provide acute hospital beds for dementia outside city boundaries.

108.3 **RESOLVED –** That this item should be referred to the Cabinet Member for Health and Social Care.

109. ITEMS TO BE REFERRED TO FULL COUNCIL

109.1 There were none.

The meeting concluded at 6:30pm

Signed Chair

Dated this day of

Mr Darren Grayson
Chief Executive
NHS Brighton & Hove
Prestamex House
171-173 Preston Road
Brighton

Date: 15 June 2009

Dear Mr Grayson

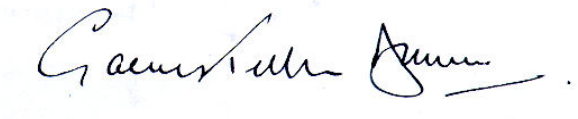
Members of the Brighton & Hove Health Overview & Scrutiny Committee (HOSC) have noted with concern recent media reports of problems with city Breast Cancer screening services. (See for example, The Brighton & Hove Argus: June 12, 2009.)

A particular worry is the allegation that women in Brighton & Hove have, on average, to wait much longer for screening services than do women in West Sussex or nationally.

HOSC members are eager to ascertain whether the position in Brighton & Hove is as bad as has been suggested. If there are serious problems with breast cancer screening services, members are also keen to learn why these problems have been allowed to develop and what steps are being taken to bring about an immediate improvement in these services.

The next HOSC meeting takes place on 08 July 2009 (with a deadline for the publication of the committee agenda and papers of 29 June 2009). If at all possible, I would appreciate a response from your trust in time for this meeting.

Yours sincerely



Councillor Garry Peltzer Dunn
Chairman, Brighton & Hove Health Overview & Scrutiny Committee

Mr Duncan Selbie
Chief Executive
Brighton & Sussex University Hospital Trust
Royal Sussex County Hospital
Eastern Road
Brighton

Date: 15 June 2009

Dear Mr Selbie

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A particular worry is the allegation that women in Brighton & Hove have, on average, to wait much longer for screening services than do women in West Sussex or nationally.

HOSC members are eager to ascertain whether the position in Brighton & Hove is as bad as has been suggested. If there are serious problems with breast cancer screening services, members are also keen to learn why these problems have been allowed to develop and what steps are being taken to bring about an immediate improvement in these services.

The next HOSC meeting takes place on 08 July 2009 (with a deadline for the publication of the committee agenda and papers of 29 June 2009). If at all possible, I would appreciate a response from your trust in time for this meeting.

Yours sincerely

Councillor Garry Peltzer Dunn
Chairman, Brighton & Hove Health Overview & Scrutiny Committee

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 7 Brighton & Hove City Council

Subject:	**The Relocation of Acute Healthcare Services in Primary and Community Settings**			
Date of Meeting:	**08 July 2009**			
Report of:	**The Acting Director of Strategy and Governance**			
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report seeks to provide a basic introduction to the issue of relocating some NHS acute hospital services to primary/community settings.

2. RECOMMENDATIONS:

2.1 That members note this report for information and determine whether they require further information on this topic.

3. BACKGROUND INFORMATION

3.1 NHS services are provided in a number of locations, including acute hospitals, primary care facilities (e.g. GP surgeries) and the community (community health centres, patients' homes).

3.2 The location of a service is determined by several factors. These include: the relative cost of providing the service in different settings; the technology needed to provide the service (which may necessitate a particular setting); staffing requirements; and access.

3.3 All of these factors can change with time. For example, recent developments in medical technology have meant that some scanning and imaging equipment which was formerly very bulky indeed (requiring its own building in an acute hospital location) is now compact enough to

be used in GP surgeries etc. without special adaptation. Similarly, changes over time in NHS budgets, in healthcare priorities, or in staffing/training regimes may make it possible to re-provide services in different setting or mean that it is no longer feasible to continue to provide a service in its current setting.

3.4 In recent years there has been a concerted attempt to re-provide a number of hospital-based services in primary/community care settings. These services typically include elements of diagnostics, out-patient appointments, specialist clinics (e.g. pain management, Warfarin etc.), and some minor surgery. There are several ostensible drivers for this policy:

(i) To provide care closer to people's homes, making access more convenient (and reducing unnecessary travel to and from hospital);

(ii) To free up hospital space for 'genuine' acute/tertiary services;

(iii) To reduce costs (the argument is that it is generally cheaper to provide services in primary/community settings than in acute hospitals);

(iv) To ensure that healthcare is provided in the most appropriate environment (the argument here is that acute hospitals can be forbidding places, and should only be used as care settings when their medical facilities are actually required);

3.5 This initiative is not without its attendant controversies. For example:

(i) Whilst few people would argue against making NHS services more accessible, it is not always clear that moving services into the community invariably improves access. Acute hospitals are generally relatively well served with public transport, parking etc. and are often in central locations. Community facilities may not be as readily accessible, so moving a service from an acute to a community setting might actually worsen access (particularly if re-provision of an acute service is in one rather than across several community facilities).

(ii) The argument for freeing up acute hospital space is strongest where there is a clear use for that space. For instance, the '3T' plans to develop tertiary services at the Royal Sussex County Hospital (RSCH) mean that any space which can be freed on the hospital site by re-locating services into the community will be available for expanding tertiary services. However, by no means all General hospitals are seeking to expand in this manner, and in

some instances there may be little or no demand for any acute space freed by service re-location.

(iii) The argument that it is cheaper to provide services in primary/community rather than acute settings has also been challenged, particularly by hospital clinicians. Whilst in most instances it probably is cheaper, in hypothetical terms, to provide a service in a primary/community setting, this is often not the whole story, as any real cost comparison should factor in continuing hospital running costs (i.e. where a hospital is not able to 'back-fill' the space freed by the re-location of services into community settings). Again, however, this is perhaps not a pertinent issue for Brighton & Hove, where it will almost certainly be cheaper to provide services in the community than to continue providing them out of the RSCH (given the pressures to expand tertiary services on the RSCH site, and the costs of new-build in instances where existing hospital space cannot be freed).

3.6 Some critics of NHS 'privatisation' (i.e. the policy of NHS commissioners encouraging a 'plurality of providers', including the independent 'for-profit' sector) have also expressed reservations about the re-location of acute services to community settings, arguing that re-commissioning in the primary/community sector effectively makes services more attractive for independent providers (who are generally better able to compete with NHS providers in this setting than in the acute sector).

3.7 However, whilst there are certainly valid questions to be asked about this policy of re-location, it is also the case that some re-locations do unambiguously improve services for local people. This is perhaps particularly the case in terms of services for people with long term conditions, where very regular (and for the patient, onerous) attendance at hospital can be replaced with structured support delivered in the patient's home (and via telecare), considerably enhancing people's ability to live independent lives.

3.8 Further information on this subject supplied by NHS Brighton & Hove is re-printed in **Appendix 1** to this report (to follow).

4. CONSULTATION

4.1 None has been undertaken in relation to the body of this report, which has been compiled by Scrutiny support officers without reference to NHS Brighton & Hove. NHS Brighton & Hove is responsible for the information contained in **Appendix 1** to this report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information

Legal Implications:

5.2 None to this report for information.

Equalities Implications:

5.3 None directly. However, the issue of healthcare settings may have considerable equalities implications as access to healthcare is widely understood to correlate meaningfully with deprivation (and in some instances with aspects of ethnicity, sexual orientation etc.) – i.e. some minority communities typically experience poorer than average access to healthcare. Therefore, plans to change healthcare settings should be made with reference to equalities issues and should aim to improve access for disadvantage groups. In taking a view on specific re-location plans, members may wish to seek assurance that an appropriate Equalities Impact Assessment has been undertaken.

Sustainability Implications:

5.4 None directly. However, the general issue of healthcare settings does have sustainability implications, particularly in terms of patient and staff travel and the use of buildings. In taking a view on specific re-location plans, members may wish to seek assurance that an appropriate assessment of travel impact has been undertaken.

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None identified

Corporate / Citywide Implications:

5.7 Improving access to healthcare for deprived/disadvantaged communities is widely seen as a key factor in lessening health (and income) inequalities, in accordance with the council's priority to "Reduce inequality by increasing opportunity."

SUPPORTING DOCUMENTATION

Appendices:

1. Information supplied by NHS Brighton & Hove (to follow)

Documents in Members' Rooms:
None

Background Documents:
None

NHS
Brighton and Hove

Relocation of Acute Healthcare Services into Primary and Community Care Settings

HOSC

20 May 2009

Developing services in a Primary and Community setting

- Why commission care closer to home?
- The national picture
- Local context and progress
- Future plans for investment?
- Future policy and direction

Why commission care closer to home?

- Focus on patient care rather than institutions.
- Acute facilities for those people who need them.
- Out of hospital, where clinically appropriate and best value for money.
- Minimize inappropriate use of acute services.
- Greater integration with primary care.
- Extended family medical services.
- Encourage plurality of provision where appropriate.
- Easier access services.
- Increaser personalization.

National Context

- Our Health, Our Care, Our say (2007)
- High Quality care for all (DH June 2008)
- National Vision for Primary and Community care (DH July 2009)
- Transforming Community services (DH January 2009)
- Personalised Care Planning (DH Feb 2009)
- Clinical Commissioning (DH march 2009)

NHS Brighton and Hove-Local context

- ‘Fit for the Future’ and ‘Best Care, Best Place’
- PCT Local vision for Primary and Community services (1994)
- Implementation of the PCT’s Estate strategy
- Strategic Commissioning Plan (December 2008)
  - Adding Years to Life
  - Maximising independence for children’s and families
  - Developing a healthy young city
  - Promoting independence
  - Commissiong nationally recognised best practice
- Proposals to develop enhanced tertiary, trauma and teaching services

Care closer to home-Better patient pathways-Improved integration-Better value for money

Example changes

Glaucoma

- Follow ups at community clinic, 175 Preston Road
- Previous long waits and busy clinics
- Longer term move to Eye Academy model:
  - Enhancing skills in community staff, more local provision of follow up clinics
  - Greater detection of undiagnosed glaucoma

Vasectomy

- Community clinic at 175 Preston Road
- Better environment, rated highly by patients

Example changes

Anticoagulation Service

- Capillary rather than venous sample – results in 10 mins
- Community Pharmacy model – Boots plus local pharmacists
- Improved clinical data for GPs
- Reduced unnecessary visits and long waits in hospital for patients

Diabetes Clinics

- Enhanced skills for management by general practice
- Introduction of 3 Community Clinics
- Increased focus on supportive self management

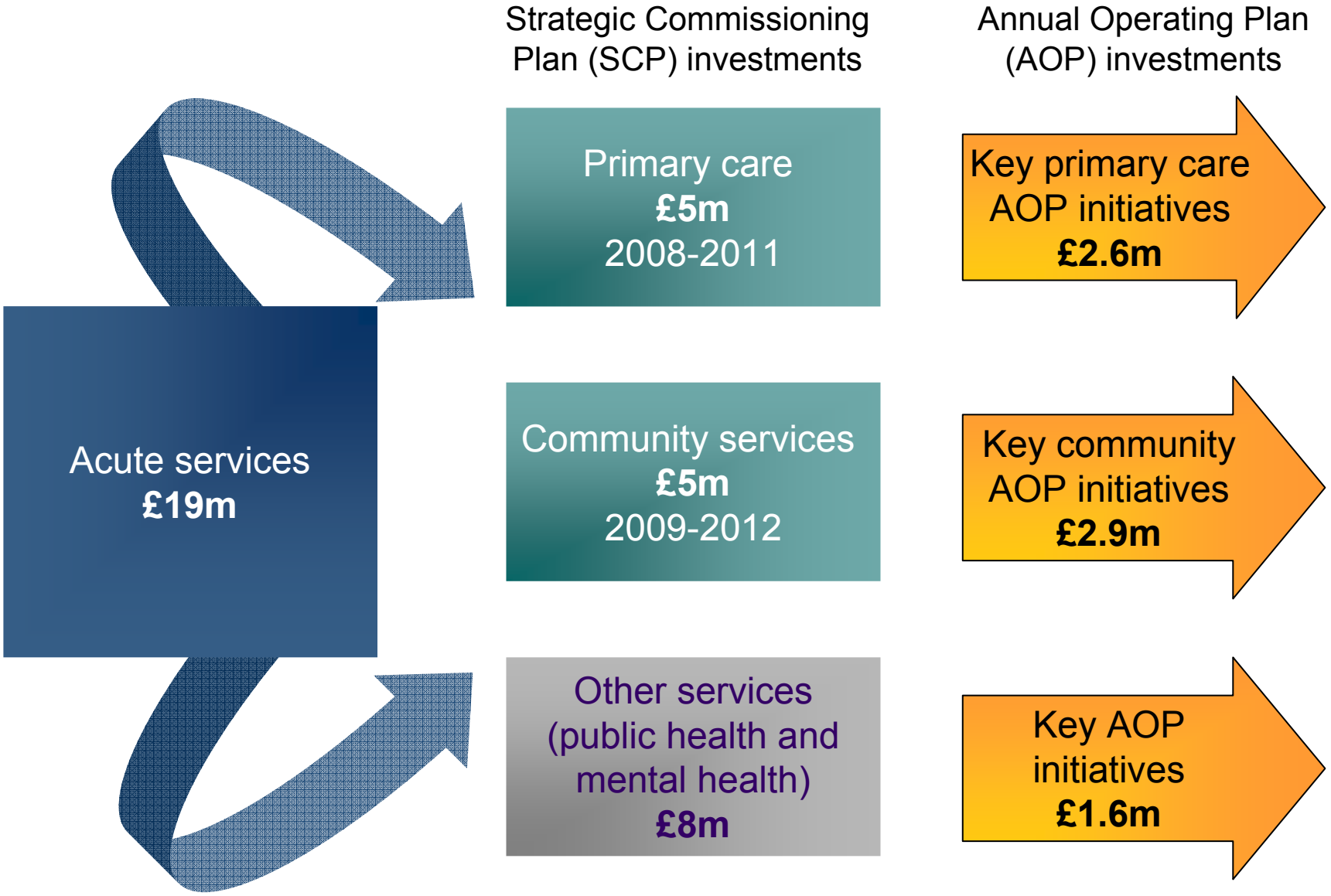
Our Plans in NHS Brighton and Hove

- Piloting Integrated Musculoskeletal services
- Developing Gateway Management and alternative community clinics
  - Headaches
  - Gynaecology and direct access to ultrasound
  - Minor eye conditions (Eye academy)
  - ENT clinics
  - Urology clinics
- Improved services for Vasectomy, Restorative dentistry and Fertility services
- Piloting Integrated Care model for a specific area with Brighton & Hove Integrated Care service (BICS)
- Vascular risk assessment in the community
- Improving access to community diagnostics including X-ray and MRI

Our Plans in NHS Brighton and Hove

- Urgent Care
- Pilot Integrated services with BSUH and South East Health - future out of hours GP services
- Central Access point for GP's to Urgent Care services - care co-ordination centre
- Roving GP for rapid assessment of elderly patients - who require a home visit during the day.
- Improved Rapid Access to assessment clinics for older people - with an urgent need.
- Improved access to diabetes care
- National 'provisional pilot' status for piloting personal budgets for the elderly
- Programme to re-commission community services - including new short term services, rehabilitation care and reducing delays.
- Improving community based stroke services- including prevention, rapid treatment, health promotion and specialist rehabilitation.
- Developing end of living care

PCT plans-use of Resouces



SCP disinvestment in acute services

Acute services
£19m

Main areas of disinvestment relate to the following areas of activity:

- Reduced emergency admissions - **£1.2m**
- Reduced A&E attendances - **£13.1m**
- Reduced outpatient attendances - **£4.5m**

These savings will be achieved by diverting activity from the acute hospital trust to alternative primary care, public health, mental health and community services settings.

Savings are predicted to occur mainly in the period 2008 – 2012.

The costs of reproviding these services in primary care and community settings are shown in the next slide

SCP reinvestment in primary and community services

Primary care
£5m
2008-2011

The main areas of investment are:

- Provision of a GP led health centre opening 8-8pm 7 days per week - **£1.3m** (2009-2010)
- Improved referral management via BICS (Brighton & Hove Integrated Care Service) - **£750k** (2008-2010)
- Provision of an Urgent Care Centre for patients presenting at Royal Sussex County Hospital - **£3m** (2008-2011)

Community services
£5m
2009-2012

The main areas of investment are:

- Improved care pathways for discharged patients requiring transition and community support - **£1.6m** (2009-2011)
- Improved long term condition management - stroke, physical disability, dementia and diabetes - **£1.3m** (2009-2011)
- Admission prevention initiatives - STAN (Single Telephone Access Number) rapid access clinics and 'Roving GP' - **£2.2m** (2009-2012)

AOP reinvestment in primary and community services

Key primary care AOP initiatives **£2.5m**

The main areas of re-investment are:

- Provision of a GP led health centre opening 8-8pm 7 days per week – costing **£1m**
- Improved referral management via BICS (Brighton & Hove Integrated Care Service) - **£160k**
- Provision of an Urgent Care Centre for patients presenting at Royal Sussex County Hospital - **£1.4m**

These will generate savings of **£3m** from reduced or diverted acute hospital activity.

Key community AOP initiatives **£2.9m**

The main areas of re-investment are:

- Improved long term condition management - stroke, physical disability, dementia and diabetes - **£1.6m**
- Admission prevention initiatives - STAN (Single Telephone Access Number), anticoagulation clinics, RACOP and 'Roving GP' - **£1.3m**

These will generate savings of **£3.1m** from reduced or diverted acute hospital activity.

Future Direction

Primary and community care strategy

- Health improvement and health inequalities
- Children and families
- Long term conditions
- Acute care and specific treatments close to home
- Rehabilitation
- End of living
- Quality and availability of Primary Medical Services

Integrated Care models

Personalisation

- Increased Integration of services across primary and secondary care
- Improving access and responsiveness
- Pilot personal budgets and care planning
- Physical disability strategy

Clinical Commissioning

3 T's

- Development of practice based commissioning
- Development of clinical reference groups for care pathways
- Managed reprovision of some District General Hospital services alongside trauma and specialist services

The context of service change….the greatest leadership challenge for the NHS?

- NHS facing a contraction in finance from 2010-11
- Need for strong leadership, radical quality and efficiency improvement will be significant and pressing
- The NHS will not remain unchanged and will need to take earlier action to bring about efficiencies and greater value for money working together with the City Council
- Reshaping services will require co design with providers and patients to inform changes to pathways and heralds opportunity
- Increasingly the NHS will need to consider the use of the market to stimulate service improvements and care closer to home for an increasing range of services

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 8 Brighton & Hove City Council

Subject:		**Development of the Working Age/Adults Mental Health Commissioning Strategy for 2010-2013**		
Date of Meeting:		**08 July 2009**		
Report of:		**The Acting Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 City partners are currently working together to plan how to update and develop the Brighton & Hove Working Age Mental Health Commissioning Strategy.

1.2 Health Overview & Scrutiny Committee (HOSC) members are asked to consider and agree the proposed process for developing the strategy (see **Appendix 1** for additional information supplied by NHS Brighton & Hove).

2. RECOMMENDATIONS:

2.1 That members consider and agree (or otherwise comment on) the proposed process for the development of the Working Age Mental Health Commissioning Strategy (reprinted in **Appendix 1** to this report).

3. BACKGROUND INFORMATION

3.1 The Working Age Mental Health Commissioning Strategy is the key strategic plan underpinning the commissioning of mental health services for working age city residents. (Mental health services for children and young people and for older people are, to some degree, discrete from working age services, and have their own strategies.)

3.2 The current strategy needs updating to bring it in line with developments in mental health services, changes to the city's demography etc.

3.3 The update will be a joint piece of work by city partners, reflecting the fact that city Working Age Mental Health services are covered by Section 75 agreements. Partners include NHS Brighton & Hove and Brighton & Hove City Council (the commissioners of mental health services), Sussex Partnership NHS Foundation Trust (the providers of statutory mental health services for city residents), and local third sector organisations providing non-statutory services or with a particular interest in mental health (e.g. MIND).

3.4 The updated strategy will need to be approved by the Joint Commissioning Board (JCB). It is anticipated that this will be scheduled for early 2010.

4. HOSC INVOLVEMENT

4.1 NHS Brighton & Hove has requested that the HOSC considers the redevelopment of the Working Age Mental Health Commissioning Strategy.

4.2 This will, of necessity, be in two stages: (i) considering the process by which the strategy is to be redeveloped; (ii) considering the revised strategy itself.

4.3 This report (and the information in **Appendix 1** provided by NHS Brighton & Hove) is intended to help HOSC members consider the process via which the strategy will be redeveloped. Members may be particularly interested in determining whether plans to update the commissioning strategy fully engage local people and stakeholder organisations.

4.4 Once completed, the revised strategy will be considered at a later HOSC meeting At that stage, HOSC members may wish to consider whether anything in the revised commissioning strategy amounts to a "substantial variation or development" of city mental health services, and if so, whether such a variation is in the best interest of city residents. HOSCs have a range of statutory powers in relation to 'substantial variations' in local NHS healthcare services (i.e. in instances where HOSC members consider that proposed changes are likely to have a negative impact upon local people's health).

5. CONSULTATION

4.1 This report has been compiled following informal discussion with officers of NHS Brighton & Hove. **Appendix 1** has been provided by NHS Brighton & Hove.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are not considered to be any financial implications to HOSC's decision at this stage. The revision of the Working Age Mental Health Commissioning Strategy is expected to take place within the current budget framework for these services, but the revised strategy may include significant financial variation within the framework.

Legal Implications:

5.2 The Health Overview and Scrutiny Committee has powers to scrutinise the NHS and represent local views on the development of local health services (Sections 7 to 10 of the Health and Social Care Act 2001). Section 242 of the Local Government and Public Involvement in Health Act 2007 has strengthened the requirements for NHS organisations to involve service users in the planning and development of services. In accordance with its terms of reference, the Health Overview and Scrutiny Committee can make recommendations regarding the process for the review of the Mental Health Commissioning Strategy, taking into account the legislative requirements for consultation.

Lawyer consulted: Elizabeth Culbert 10th June 2009

Equalities Implications:

5.3 Mental illness impacts on all parts of society, but particular groups may be disproportionately affected (e.g. people from deprived communities, from certain minority ethnic groups and from the lesbian, gay, bisexual and transgender community may be more likely than average to suffer particular mental health problems). It is therefore important that the needs and views of these communities are considered when redeveloping the Working Age Mental Health Commissioning Strategy.

Sustainability Implications:

5.4 None identified.

Crime & Disorder Implications:

5.5 People with mental health issues may feature to a disproportionate degree as the perpetrators, and more particularly, as the victims of crime and disorder. It is therefore important that crime and disorder

issues are considered when redeveloping the Working Age Mental Health Commissioning Strategy, and the appropriate groups consulted.

Risk and Opportunity Management Implications:

5.6 None identified at this stage in the development of the commissioning strategy.

Corporate / Citywide Implications:

5.7 None identified at this stage in the development of the commissioning strategy.

SUPPORTING DOCUMENTATION

Appendices:

1. Information supplied by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

The Health and Social Care Act (2001)

Appendix 1

WAMH Joint Commissioning Strategy Development Steering Group

Terms of Reference

1. To oversee the process of developing the joint commissioning strategy

2. To consider the implications of the any new national mental health strategy and the impact on local commissioning strategy

3. To ensure the relevant sections are completed by the relevant organisations and people within organisations

4. To oversee any verification process required within organisations

5. To ensure that drafts are consulted on appropriately within organisations

6. For the commissioners on the group to agree the strategy to be presented to the JCB on 25th January 2010

7. The up will meet as in the timeline below and support the communications plan

The responsibility for this strategy is joint between the City Council and the PCT.

It will contain an agreed:

- vision for the future based on outcomes
- plan for future commissioning
- financial investment
- initiatives for investment
- contracting arrangements
- performance management arrangements

Membership

PCT

Simon Scott (Mental Health and Substance Misuse Strategic Commissioner)

Claire Quigley (Director of Delivery)

Margaret Cooney (Project Manager)

Stephen Ingram (Primary Care Strategic Commissioner)

Geraldine Hoban (Deputy Director Commissioning)

Kathy Caley (Older Peoples Commissioner)

Matt Johnson (Elective Care Strategic Commissioner)

Jane Simmons (Head of Partnerships and Engagement)

Martin Campbell (Patient and Public Engagement Manager)

Kate Kedge (Contracts Manager)

City Council

Denise D'Souza (Director of Community Care)

Philip Letchfield (Interim Head of Adult Social Care)

Tamsin Peart (Commissioner for Carers)

Daniel Parsonage (Supporting People)

Andy Staniford (Housing Strategy Manager)

Sussex Partnership NHS Foundation Trust

John Rosser (Service Director, Adult Mental Health

Tony Sharp (Head of Business Planning

Terry Pegler (Associate Director – Social Care)

Third sector Sarah Danily (Director B&H MIND)

LINK representative Simon Hubbard

Carers Centre Sue Wallace (Carers Centre Chair)

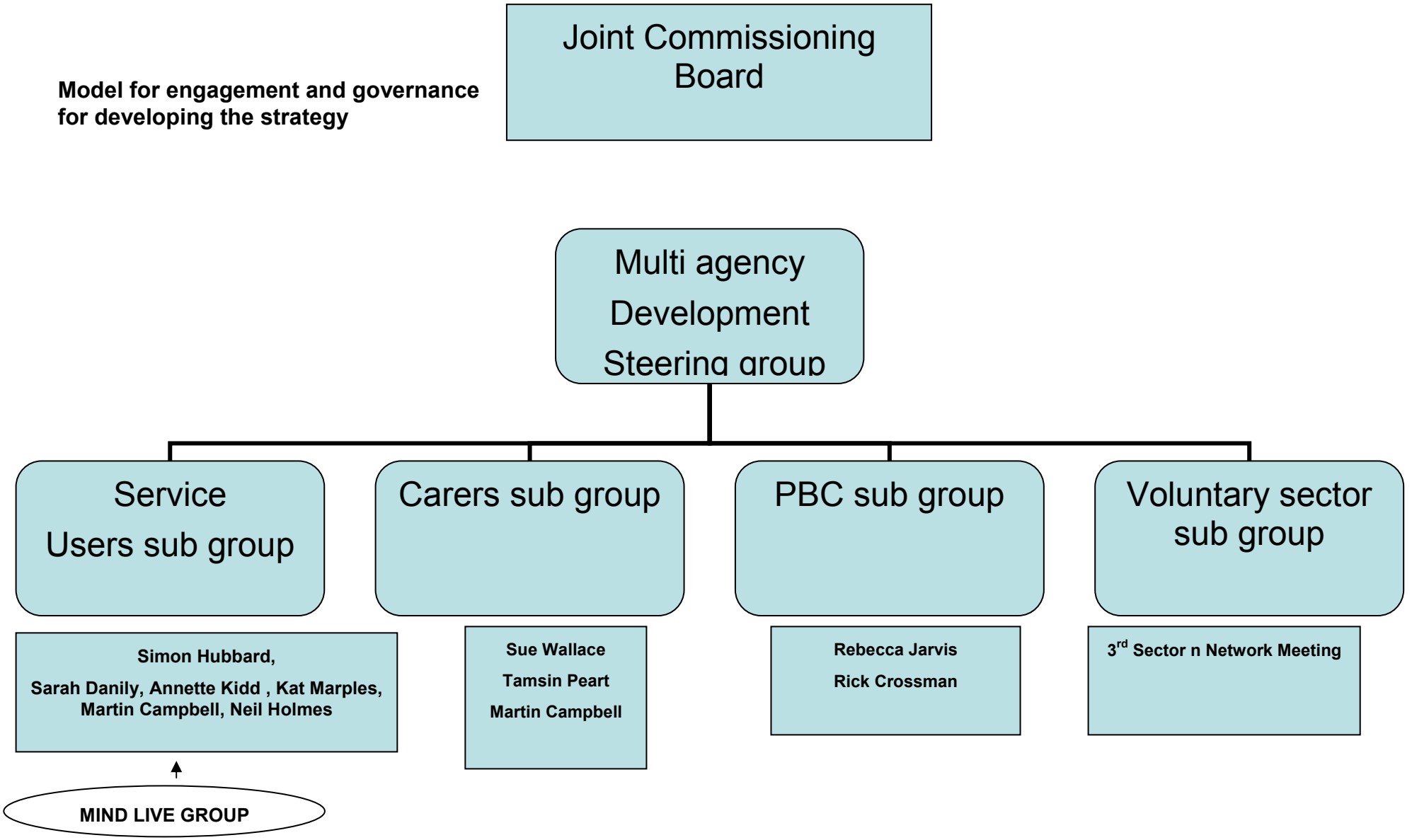
Clinical Representatives

Dominic Osman Allu (Clinical Executive) Rebecca Jarvis (PBC)

Timeline for development of the strategy including engagement and governance

	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Steering group	16th										
Carer ref group		8th									
User ref group		29th									
LIT meeting		29th									
Vol. sector network		30th									
Vol. sector network			11th								
Steering group			27th								
ASC DMT				11th							
PCT PEC				16th							
HOSC					8th						
User ref group				10th							
Steering group				29th							
Vol sector network					7th						
Consultation period					→	→	→				
Steering group							7th				
LIT meeting								tbc			
Steering group								30th			
Presented to JCB										18th	25th

Model for engagement and governance for developing the strategy



HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 9** Brighton & Hove City Council

Subject:	**Ad Hoc Panel Report on the Procurement of a Brighton & Hove GP-Led Health Centre**	
Date of Meeting:	**08 July 2009**	
Report of:	**The Acting Director of Strategy and Governance**	
Contact Officer:	Name:	Giles Rossington Tel:
	E-mail:	Giles.rossington@brighton-hove.gov.uk
Wards Affected:	All	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report and its appendices detail the findings of the Scrutiny Panel established to examine the issue of the procurement of a Brighton & Hove GP-Led Health Centre.

1.2 The Scrutiny Panel's report is re-printed as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members endorse the ad hoc panel report and its recommendations.

3. BACKGROUND INFORMATION

3.1 A GP-Led Health Centre is a GP practice offering standard GP services to registered and non-registered patients on an appointment or 'walk-in' basis. These Health Centres operate extended opening hours (typically 8am - 8pm, 7 days a week).

3.2 GP-Led Health Centres are a recent Department of Health initiative, with each Primary Care Trust in England required to provide a centre for its residents

3.3 More details on the GP-Led Health Centre initiative and the Brighton & Hove Health Overview & Scrutiny Committee (HOSC) involvement with this project may be found in the body of the ad hoc panel report (see **Appendix 1**).

4. CONSULTATION

4.1 Officers of NHS Brighton & Hove have been informally consulted on the contents of the ad hoc panel report on the GP-Led Health Centre.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none to this report.

Legal Implications:

5.2 In accordance with Part 6.1, section 15, of the Council's constitution, if the Committee agrees the recommendations of the Scrutiny Panel, it is required to prepare a formal report and submit it to the Chief Executive for consideration by Cabinet or the relevant Cabinet Member. Only if one or more recommendations require a departure from or a change to the agreed budget and policy framework would the report need to be considered by Full Council.

If the Committee cannot agree on one single final report, up to one minority report may be prepared and submitted, alongside the majority report, for consideration by the Cabinet or Cabinet Member.

Lawyer consulted: Elizabeth Culbert *Date: 11 June 2009*

Equalities Implications:

5.3 None directly. GP-Led Health Centres are intended to address problems of under-registration to GP services. In some instances, under-registration correlates meaningfully with membership of certain deprived/excluded groups (e.g. rough sleepers), and members may wish to be assured that relevant equalities issues have been considered by NHS Brighton & Hove when planning the establishment of a local GP-Led Health Centre.

Sustainability Implications:

5.4 None directly. GP-Led health Centres are intended to provide a convenient and easily accessible primary care facility for all city residents. Members may wish to receive assurances that issues of access and transport sustainability have been considered by NHS

Brighton & Hove when planning the establishment of a local GP-Led Health Centre.

Crime & Disorder Implications:

5.5 None identified.

Risk and Opportunity Management Implications:

5.6 None identified.

Corporate / Citywide Implications:

5.7 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. The ad hoc panel report on procurement of the Brighton & Hove GP-Led Health Centre.

Documents in Members' Rooms:

None

Background Documents:

None

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.[1]

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 this 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

[1] 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 which 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.[2]

2.3 Polyclinics

[2] The only area to qualify as 'under-doctored' in the South East Coast Strategic Health Authority region is Medway.

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.[3] 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[4], usually (although not necessarily) in a single building.[5] 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.[6]

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 the level 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. Coalescing small local practices into larger, purpose-built facilities with

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[3] 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.)

[4] 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.

[5] Some polyclinics may be 'virtual' – a network/federation of existing GP practices rather than co-siting in a single locality.

[6] Helpfully, under Darzi's definition, Hove Polyclinic is not a polyclinic as it does not host GP services.

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.[7]

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.

[7] 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.[8]

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 option 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 chosen.

[8] Thus there is no argument for locating the Centre in, say, East Brighton (the city's principle under-doctored area), unless such a location fits 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.[9]

[9] 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.[10] 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 is not suggested 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.

[10] 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 them 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 in 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. This guidance determines the basic structure of a procurement process, but there is typically 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).[11] 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 etc).

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.[12] 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 bid.[13] This may change in the relatively near future, as recent

[11] In this instance it seems that the bidders re-assessed their application, and deciding that it would be rejected at evaluation, chose to withdraw it at this point.

[12] '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.

[13] The GP-Led Heath 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.

developments in Practice Based Commissioning Groups[14] and in the creation of the Brighton Integrated Care Service (BICS)[15] 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.[16]

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 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

[14] 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).

[15] 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 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.

[16] Organisations awarding contracts via competitive tender must ensure that they do not favour one bidder over another. For instance, they must ensure that information or guidance offered to one bidder must also be offered to all other applicants.

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 large degree unavoidable, although NHS Brighton & Hove officers did suggest that, whilst this is the case for individual tenders, it may 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 the 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.[17]

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 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

[17] 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.

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 not be the case that extra money will be provided to top up an unrealistically low bid.[18]

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. (Had the bid been outside the expected parameters it might well have caused 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. It is generally considerably cheaper to employ permanent staff rather than locums (as locum rates of pay are higher).[19]

(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.[20]

(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

[18] 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.

[19] '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.

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

(general admin, Human Resources, 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 and treatment of 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.

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 in conducting all elements of 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 true 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 true 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.[21]

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 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.

[21] 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.

It is also the case that the GP-Led Health Centre contract has been designed so that it contains many enforceable performance indicators (PIs). 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 unlikely to go away, 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 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[22] 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.)?

- 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

[22] Until recently this role was undertaken by the Healthcare Commission.

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 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 the 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.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 10 Brighton & Hove City Council

Subject:		**Organisations in the Local Health Economy**		
Date of Meeting:		**08 July 2009**		
Report of:		**The Acting Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report seeks to provide basic information about the range of organisations delivering publicly-funded healthcare to Brighton & Hove residents.

1.2 These organisations include NHS trusts, but also voluntary and private sector organisations.

1.3 **Appendix 1** to this report contains information on the range of providers commissioned by NHS Brighton & Hove. This list has been supplied by NHS Brighton & Hove (copy to follow).

2. RECOMMENDATIONS:

2.1 That members consider this report and determine whether they require any additional information at this juncture.

3. BACKGROUND INFORMATION

3.1 When the NHS was formed in 1948, the bulk of the nation's hospital provision was taken into public ownership. However, not all NHS services were nationalised: primary care services (GP practices, dentists, community pharmacies, opticians) essentially continued to be delivered by the small independent businesses that had previously provided them, a position which is largely unchanged today.

3.2 Recent years have seen significant changes in NHS healthcare, with a growing enthusiasm for market economics leading to a variety of initiatives (under both Conservative and Labour governments) which have sought to encourage a 'plurality of providers' – i.e. to involve other sectors of the economy in the delivery of publicly-funded healthcare.

3.3 A wide variety of organisations currently provide publicly funded healthcare services. In addition to NHS trusts, these range from charities (some of which may have been involved in healthcare long before the inception of the NHS), through a variety of voluntary sector organisations, to the not-for-profit independent sector (BUPA, South East Health etc.), to profit making small businesses (including GP practices), and profit making corporations (United Healthcare etc.). More details of the organisations providing services for Brighton & Hove residents can be found in the appendices to this report.

3.4 Locally, all of these providers are commissioned by NHS Brighton & Hove on behalf of local residents. This means that the PCT is responsible for assuring the quality of services delivered by these providers.

3.5 Health Overview & Scrutiny Committees (HOSCs) have no specific statutory powers in respect of non-NHS providers, although there are statutory powers of scrutiny in terms of the PCT commissioning of these services. However, there is no reason why HOSC should not attempt to engage with non-NHS providers, and invite them to meetings etc.

4. CONSULTATION

4.1 Officers of NHS Brighton & Hove have been consulted on the contents of this report and have provided the information re-printed in **Appendix 1**.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information

Legal Implications:

5.2 None to this report for information

Equalities Implications:

5.3 None

Sustainability Implications:

5.4 None

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 None

Corporate / Citywide Implications:

5.7 None

SUPPORTING DOCUMENTATION

Appendices:

1. Information supplied by NHS Brighton & Hove (to follow)

Documents in Members' Rooms:

None

Background Documents:

None