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**			
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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