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Dear Christine

Proposed integrated care pilot scheme between City Hospitals Sunderland NHS Foundation Trust and Church View Medical Practice

Thank you for your email dated 15 June 2009. Please find set out below the views of NHS North East on the issues you outlined as requiring consideration by the Co-operation and Competition Panel ("CCP").

Background Information

NHS North East is committed to the concept of system management, with a primary focus on the needs of the patient and patient choice. In order to ensure a safe, appropriate and measured approach to system management, NHS North East is fully committed to implementing the *Principles and Rules of Cooperation and Competition*, as published by the Department of Health in December 2007. A regional framework for system management has been developed and implemented in the North East, which includes a Regional Commercial Committee and appropriate Dispute Resolution Policies at SHA and PCT level.

The SHA has developed an approach to obtaining robust assurance from PCTs that in any instances of vertical integration, the risk around choice and supplier induced demand has been assessed and the proposed contractual safeguards implemented. This has initially been discussed at the World Class Commissioning and System Management Sub-Group and will be endorsed at our Regional Commercial Committee.

This approach and principles were developed as part of the "*Equitable Access to Primary Medical Care (EAPMC)*" procurements of GP-led Health Centres and GP Practices and based on DH guidance specific to the procurement programme.

Application of the Principles and Rules of Cooperation and Competition

Our view is that this arrangement falls with Principle 10, as follows:



Sir Peter Carr CBE
Chairman

Ian Dalton
Chief Executive

“Vertical integration is permissible when demonstrated to be in patient and taxpayers’ best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.”

As set out in the *Principles and Rules* document, the actions/behaviours that apply in this situation are as follows:

- (1) Where vertical integration is proposed by a provider, commissioners must ensure there are sufficient safeguards in the contract to mitigate against inappropriate referrals.
- (2) Before agreeing to any vertical integration activity, commissioners should consider the degree of patient choice that will be present after the change is made.

As set out in the *Principles and Rules* document, the rules that apply in this situation are as follows:

- (1) Commissioners should not contract directly with secondary providers seeking to own, manage or control general medical list based services that would result in referrals to their own secondary provision function, without having agreed robust and proportionate safeguards and with the express agreement of the DH.
- (2) Providers must obtain prior written consent from the co-ordinating commissioner before exercising a change in control NHS Contract clause 49.
- (3) Parties to the contract must declare conflicts of interest NHS contract, clause 53.
- (4) All referring clinicians (such as general practitioners and hospital consultants) must tell their patients about any financial or commercial interest in (or are employed by) an organisation to which they plan to refer a patient for treatment or investigation. When treating NHS patients they must also tell the commissioner (GMC Good Medical Practice 2006, paras. 74 –76). This interest will also be declared on NHS Choices.

Views of NHS North East

We set out below our views on the proposed integrated care pilot scheme:

- (1) ***Pilot Status***: we note that the proposed arrangement is an integrated care pilot scheme. We believe that such a pilot will be an invaluable opportunity to test new and innovative ways of working through integration. We hope that through the removal of certain barriers the pilots will demonstrate improved outcomes in terms of quality of care and patient experience. We will expect the PCT to evaluate the scheme at the end of the pilot period to ensure there are clear benefits for patients and that patient choice is not compromised.
- (2) ***Availability of medical practices in the surrounding area***: we note that there are a number of medical practices in the surrounding area. Most notably, there are two practices in the immediate vicinity i.e. less than 1 mile, both with open lists and accepting new patients. There are a further four practices less than 1.5 miles away, also with open lists. We believe that patients therefore have a choice of GP services, similar to those provided by Church View Medical Practice.

(3) **Choice of Healthcare services:** we note that the majority of patients who are registered with Church View Medical Practice already choose to have hospital treatment at City Hospitals Sunderland NHS Foundation Trust, reflecting the local market and preferences. Local data indicates that for 2008/09, 85% of elective admissions and day cases from the practice went to City Hospitals Sunderland NHS Foundation Trust. The GP Access and Choice Survey for 2007/08 also indicated that 100% of patients from Church View Medical Practice recall being offered a choice of hospital. We believe that, with appropriate commissioner-led assurance of the degree of patient choice that will be present after the merger and the safeguards in place, that the proposed arrangement will not therefore have a negative impact on patient choice in the area.

We have recommended to the PCT that contractual safeguards are included in the PMS contract comparable to those included in the APMS contracts for the GP-led Health Centres and GP Practices procured as part of the EAPMC programme.

These may include the following:

- The PCT ensures visibility of referral patterns, for example collection and benchmarking of monthly referral information and an explanation of unusual referral patterns e.g. of increases of 5% or more.
- The provider is required to confirm that they provide full and fair information to patients on the choices available to them. This also includes stating any financial or commercial interest in the organisation to which they plan to refer a patient for treatment or investigation at the point of referral.

We are therefore supportive of the pilot on the basis that the PCT as the commissioner is supportive and has assessed the relevant risks to choice and supplier induced demand and included relevant safeguards to mitigate against inappropriate referrals.

Further information

We hope that the CCP finds the above information useful in its evaluation of the proposed integrated care pilot.

If you would like any further information, please do not hesitate to contact Alison King or Nicola Wright

Yours sincerely

Richard Barker
Director of Operations and Performance