**NHS Overview and Scrutiny Briefing Note**

**Whitstable Polyclinic**  
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**Introduction**

Whitstable Medical Practice, a local GP practice, is developing plans to establish a polyclinic offering NHS care in Whitstable, in partnership with a for-profit healthcare company.

This idea is still at the proposal stage and has yet to be formally considered by the local NHS health community. Nevertheless, the project has already been the subject of comment in the local area.

**What is a polyclinic?**

A polyclinic is a relatively small healthcare facility, serving a local community and hosting a wide range of health services – including some that have, within the NHS, traditionally been provided in acute hospitals.

Polyclinics have long been major features of healthcare systems in some countries. In the Soviet Union, the greater part of healthcare was provided through polyclinics that combined the role of a hospital outpatients department with that of a general medical practice and served populations of several thousand. In Cuba, polyclinics serving populations of around 30,000 provide GP services and a range of specialties, as well as diagnostic services. Germany has some 400 polyclinics. These are mostly a legacy of the health system in the former East Germany – but new polyclinics have begun to be established as part of far-reaching healthcare system reforms.

**NHS system reform**

The various strands of NHS system reform make up the context in which the Whitstable Polyclinic plan has arisen:

The shift to primary care

The White Paper *Our health, our care, our say: A new direction for community services*, published by the Department of Health in January 2006, sets out an agenda for providing NHS care “closer to home”. It argues that shifting services from acute hospitals into primary care will be popular, and will provide better and cheaper care more conveniently for patients, while facilitating a greater emphasis on the prevention of illness and the managing of chronic conditions.

The White Paper makes explicit reference to the new German polyclinics as a model for providing care in a community setting. It also refers to the American “Health Maintenance Organization” (health insurance company) Kaiser Permanente. Some researchers have concluded that this company achieves better health outcomes than the NHS, and at lower
cost, by emphasising integrated care closer to home. (This research has, though, been controversial. Some health-policy academics have argued that Kaiser Permanente, as an insurance organisation charging risk-based premiums, is not comparable to the NHS, which is a tax-funded service providing care for all on the basis of need.)

**Patient Choice**

The government has argued that a key way to drive up standards and efficiency in the NHS is to allow patients to choose, at the point of referral, which healthcare provider they will be treated by. Since 1 January 2006, all patients needing planned hospital care should have been offered a choice of four or more providers (usually including at least one private-sector provider) from a local (Primary Care Trust) menu, where clinically appropriate.

In addition to the four or more local-menu options, since last year, patients have been able to choose from a national menu encompassing the “Extended Choice Network”. This includes all NHS Foundation Trusts, all centrally-accredited Independent Sector Treatment Centres and other centrally-procured Independent Sector providers.

From 2008, NHS patients will be able to choose any healthcare provider (including non-NHS providers) that meets appropriate standards (as certified by the Healthcare Commission) and is prepared to provide care at the NHS tariff rate (see below). This is known as the “Free Choice” initiative.

Consideration is being given to further extensions of Choice to hitherto excluded areas (such as mental health and maternity services) and other “choice points” along the patient pathway. The application of Choice to primary care is apparently also being looked at by the Department of Health.

**Plurality of providers**

The government is committed to seeing a plurality of providers in the quasi-market that is emerging in the NHS as a result of system reform. It believes that “contestability” of services between NHS providers and others (both for-profit organisations and voluntary-sector/charity/not-for-profit/“Third Sector” bodies) will drive up standards, improve efficiency and makes services more responsive to patients’ wishes.

**Payment by Results**

NHS acute Trusts in England are now substantially being paid by commissioners on the basis of the Payment by Results (PbR) system. Under PbR, work is paid for through “cost and volume” contracts according to the actual number of episodes of care (“spells”) provided. This is in contrast to the old system of block contracts, whereby commissioners pay for pre-determined volumes of work.

Under PbR, payment for each procedure is made according to a standard national “tariff”, based on average costs across NHS providers (there is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the Market Forces Factor). The tariff is structured around “Healthcare Resource Groups” (HRGs), which are used to classify together treatments, and types of case, that are clinically similar and that use roughly the same level of resources, taking account of diagnosis, the actual procedure
involved and other variables (such as the patient’s age). Doubts have been expressed as to whether HRGs actually do ensure that providers are adequately compensated for undertaking costlier and more difficult work.

It is intended that the scope of PbR will be extended to cover as much of hospital care as possible (including emergency care) and other areas, such as mental health.

By its very nature, the national tariff disadvantages those Trusts with above-average costs (of which East Kent Hospitals NHS Trust is one) and favours those with below-average costs. Under PbR, “underperformance” (lack of patient referrals or insufficient patient throughput) can financially destabilise a Trust.

**Practice-based Commissioning**

Under Practice-based Commissioning (PbC), GPs are now able to take responsibility for the budgets in respect of their patients, under a system that is similar (although not identical) to that of GP fundholding, which existed in the 1990s. Commissioning of services is effectively devolved from the Primary Care Trust to the GP practice (or to “locality clusters” of GP practices, which are akin to the “Multifunds” that existed under Fundholding).

Where GPs are able to make savings in commissioning services for their patients, the money saved can be reinvested back into their practice. PCTs still hold the actual contracts with providers and deal with payments to them (GPs only have “indicative budgets” – as opposed to cash budgets – for commissioning). GP commissioning budgets are currently based on historic practice utilisation of healthcare resources, but it is planned to move to a “weighted capitation” formula (of the type already used to allocate funding to PCTs).

Involvement in PbC is voluntary – since GPs are independent contractors, they cannot be obliged to participate. However, the government expects and intends that all GPs will wish to take up the opportunities presented by PbC.

**Whitstable Medical Practice**

Whitstable Medical Practice is a large GP practice, with 17 GPs working from two locations (Whitstable Health Centre and Chestfield Medical Centre), serving 31,000 patients. The practice operates under a Personal Medical Services contract (these contracts were introduced to give GP practices greater scope to be flexible and innovative in delivering services). The practice is involved in the “GPs With Special Interests” scheme (to allow GPs to undertake more specialist work), and in doctor and nurse education; the practice is also research-accredited.

Under GP fundholding, the practice operated as part of a large local Multifund. The practice has now adopted PbC and is providing a number of services that were previously commissioned from East Kent Hospitals NHS Trust at a rate below that charged by the Trust.

**The polyclinic plan**

Whitstable Medical Practice proposes to open a new GP surgery at Seasalter, co-located
with a community pharmacy, an NHS ambulance response base and a surgical polyclinic. The GP practice would provide services for NHS patients under Whitstable Medical Practice’s contract with Eastern and Coastal Kent PCT. As well as a full range of GP services, it is intended to provide a comprehensive range of nurse-led chronic disease management clinics and minor illness clinics. Consulting rooms would also be made available to staff from Social Services, mental health services and other such agencies.

The new GP surgery, it is stated, would allow Whitstable Medical Practice to expand (having outgrown its two existing two surgeries) and bring much-needed primary-care services to the Seasalter area.

The co-located polyclinic would provide for NHS patients:

- consultant-led surgical outpatient services;
- day-surgery, conducted in an operating-theatre suite;
- diagnostic services – including x-ray and ultrasound; and visiting CT and MRI scanning services (using mobile equipment in a docking facility).

It is stated that these plans are designed to complement Phase 2 in the redevelopment of Whitstable and Tankerton Community Hospital – subject to the outcome of the review of all the community hospitals along that part of the Kent coast, which is currently being undertaken by Eastern and Coastal Kent PCT.

Application has apparently been made for funding of £2.16 million from the £750 million fund for community hospitals and other such primary-care facilities announced by the Secretary of State for Health in 2006. This sum would cover both the cost of the GP element of the Seasalter plan and the redevelopment of Holden Ward at the community hospital. This would be a cash grant from the NHS centrally and would not be deducted from the existing PCT budget. The PCT would apparently own the GP practice building and charge Whitstable Medical Practice rent for the use of it.

The cost of the actual polyclinic, which is estimated at around £5.2 million, would come from the private-sector partner in the project, Centres of Clinical Excellence (CCE – see below).

NHS services at the polyclinic would be provided by local consultants, working for CCE. Patients would be able to choose to use the service under the Free Choice initiative (see above), on referral from their GP; and CCE would be paid under the PbR system (see above). Referring GP practices would, under PbC (see above) be able to retain the difference between the price charged by CCE for work undertaken and the NHS tariff.

**Centres of Clinical Excellence**

CCE was set up by its Chairman, Ali Parsa, an entrepreneur and former merchant banker. It uses a “clinician investor” model, whereby the consultants (and, in future, other staff) who will be working for the company own a proportion of the shares and will receive at least half the profits. Over 300 consultants have reportedly joined CCE.

According to Mr Parsa, the company has secured capital that “significantly exceeds £100m” from investors, and it plans to use this to set up, by 2010, a network of 20 (or “maybe double that”) “health campuses”, combining polyclinics with GP and dental
surgeries, as well as facilities such as pharmacies and gyms.\(^1\)

CCE is also a provider of NHS services within the Extended Choice Network (see above) under a five-year contract agreed with the Department of Health in 2006 as part of the second-wave of central Independent Sector procurement.\(^2\) It appears that PCTs are not obliged to use the full value of these contracts, so contractors are not guaranteed payment regardless of activity levels (in contrast to Independent Sector Treatment Centres).\(^3\)

Mr Parsa has told the press that: "We wish to act as a conduit for the City to invest in UK healthcare. One of our investors is a multibillion pound institution." He has also said: "We are all people from big business. We have managers from the major consultancies and senior executives of healthcare corporations with more than 100 years' experience of the sector. We may be a start-up, but we are people from big business starting up a big business. I would be astonished if we couldn't be in the same league as BMI [the UK market leader] within 10 years … But size is not as important as quality. Our motive is to be the best healthcare organisation in the UK."\(^4\)

CCE has a partnership arrangement with Harvard Medical International (a subsidiary of Harvard Medical School), which has noted that "Many private health care organizations, including CCE, expect the NHS to become the purchaser, rather than provider, of health care services, utilizing a bidding process".\(^5\)

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\(^1\) *Guardian*, 3 October 2005.

\(^2\) *The Times*, 31 August 2006.

\(^3\) *Independent Practitioner*, October 2006.

\(^4\) *Guardian*, 3 October 2005.