Annex B

Department of Health

EXECUTIVE SUMMARY

Transforming Community Services:

Enabling new patterns of provision

NHS

DH INFORMATION READER BOX

Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning/	Finance
Clinical	Social Care/Partnership Working

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Description	This enabling guidance is intended to help PCT providers of community services to move their relationship with their commissioners to a purely contractual one, consider what type(s) of organisations would best meet the future needs of patients and local communities, and how change can be managed to support the transformation of services to patients.
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High Quality Care for All has set a clear overall vision – to make quality the organising principle for the NHS. It defines quality as spanning three areas: patient safety, patient experience and the effectiveness of care. These three things taken together will make a quality service. This will require transformational change – by clinicians and other front-line staff, by the organisations providing community services and by commissioners.

Our vision for primary and community care[1] made a public commitment to creating modern, responsive community services of a consistently high standard. We believe that this is what patients and communities need and deserve, and what staff want to deliver.

This is why we have placed quality and enabling transformational change at the core of the Transforming Community Services programme. We have already begun to co-produce with the NHS a Quality Framework for community services. This is being designed to reflect the particular circumstances and challenges of community services. An equally high priority is enabling transformational clinical practice – disseminating best practice and investing in developing clinical and leadership skills.

In parallel, we need to transform the commissioning of community services. We are doing this through World Class Commissioning, and by providing commissioners with the tools they need to drive service improvement – a new standard contract, guidance on costing and pricing, information and metrics.

But to secure modern, high quality community services we also need to ensure that the organisations providing them are fit for purpose. We need modern organisations, which enable and empower front-line staff to innovate and free up their time to care for patients. Organisations which empower all clinicians to shape the future of community services, and provide them with the support and resources they need to be world class practitioners. Organisations which have a robust business infrastructure, capable of contracting with commissioners and effective business planning. Such organisations also need to be sustainable and flexible – capable of evolving to meet an increasingly challenging environment of rising patient expectations, more demanding PCT and practice-based commissioners (wanting higher service quality, more effective targeting of resources to need, and better value), and increasing patient choice.

The aim of this enabling document is to help providers of community services to meet these challenges by considering what type(s) of organisations would best meet the needs of patients and local communities (informed by a thorough needs analysis), and how such change can be managed well to support the transformation of services to patients. This includes following good workforce practice, and timely and sustained engagement with key local stakeholders. Retaining skilled and well-motivated teams of clinical and non-clinical staff during a period of change will be

[1] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

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a critical factor in maintaining and improving the quality of provision of services to patients. Early engagement with staff and their trade unions will be central to the success of a strategic approach to transforming community services.

There is no national 'blueprint'. Decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities. To help support local decision-making, a set of guiding principles should underpin this transformational change. These include:

- the interests of patients and carers must be paramount;
- quality is the organising principle – organisations must enable the provision of safe, effective, personalised care. This will require the capacity and capability for transformational service change;
- a pre-requisite for PCTs is a clear commissioning strategy, with improving quality and reducing inequalities at its core;
- proposals must also be able to deliver value for money for tax-payers;
- decisions about how services are provided should be led and made locally, with robust consultation processes;
- recognition that services differ in their characteristics and the people they serve, and therefore that different solutions may suit different services, even within the same locality;
- the early and continued involvement of staff, trade unions and stakeholders before any decisions are made;
- high standards of human resource management should be followed;
- assurance, approval and authorisation processes must be clear, robust and transparent;
- proposals must enable integrated care including with Local Authority services where appropriate, World Class Commissioning and patient choice;
- proposals must fit with the Department's published *Principles and Rules for Cooperation and Competition*;
- options are equality impact assessed;
- provision of safeguards for service continuity, assets[2] and staff pensions.

[2] Control of current PCT property should be protected in the interests of taxpayers and to ensure that commissioners have sufficient leverage to drive change and improve quality. As a rule, property will not be transferred to providers and PCTs will be encouraged to develop strategic partnerships that make the best use of estate.

One of the reasons for producing this guidance is the current highly variable pace of organisational change to services directly-provided by PCTs. Decisions should be led locally, but it is in everyone's interest that change is managed coherently, to high standards, and reflects the consistent application of common guiding principles and criteria. As part of good leadership and to reduce uncertainty, all PCT boards should start to engage their staff, unions, communities and stakeholders about the likely future direction for the provision of their community services.

The requirement to *'create an internal separation of their operational provider services, agree SLAs, based on the same business and financial rules as applied to all other providers'* was included in the NHS Operating Framework for 2008/09. Therefore **by April 2009 all PCT direct provider organisations should have moved into a contractual relationship with their PCT commissioning function, using the national contract for community services in 2009/10**. This means ensuring sufficient separation of roles within the PCT to avoid direct conflicts of interests.

It is anticipated that, **by October 2009**, PCT commissioners, working closely with their practice-based commissioners, will have developed a detailed plan for transforming community services, including how they intend to enhance patient choice, for agreement with their SHA. To the same timescale, PCT provider services should review (in consultation with local staff and trade unions) and assure themselves that they have the best governance arrangements to sustain high quality community services that best suit local need and circumstances, and whether to declare an interest in establishing new governance arrangements, such as a social enterprise or Community Foundation Trust.

There is a range of potential options for providing community services, from PCT provider services (which will continue to be an option where well-led, well-managed and more business-like), through Community Foundation Trusts, social enterprises for which there is a right to request, integration with other NHS organisations, and PCTs contracting with integrated care organisations, or non-NHS bodies. Different forms may suit different services and hybrid organisations derived from more standard original models may well emerge as systems evolve. *There is no prescribed ideal form and it is a matter for local determination.*

Key points for Chief Executives

> the drivers are for modern, innovative community services that have direct benefits for patients, are responsive to local need, and promote seamless care through increased opportunities for integration of health and social care services;

> there is a clear timetable for PCT provided services to move into a contractual relationship with their PCT commissioning arm, and to develop plans for transforming community services and options for future organisational forms. PCTs can move more quickly provided certain requirements are met;

- ensure clarity about the future ownership of assets;
- ensure robust arrangements are in place for staff engagement and trade union consultation throughout the process;
- the processes outlined enable a PCT to commissioning fairly, whilst developing its in-house provider to become business ready, exercise a right to request, and have "first call" in the initial stages;
- the leadership, capability and capacity of the provider sub committee needs to be of a sufficiently high calibre to take forward new patterns confidently and competently, with appropriate development programmes to enable this;
- services and business continuity must be maintained during these management changes so that patient care is not compromised;
- the SHA has a clear role in assuring the process leading to the PCT Board decision of new patterns of community service provision.

Key points for PCT Boards

- the evidence of benefits to patients and value for the taxpayer of options must be clearly demonstrated;
- decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities;
- the process is underpinned with robust governance arrangements;
- the role and responsibilities of Non-Executive Directors (NEDS) are discharged in a manner which allows them to fulfil the terms of their appointment to the corporate PCT Board;
- the inevitable split of the Board is managed in such a way to expose and manage conflicts of interest in an open, transparent manner;
- the interests of the workforce are appropriately addressed and safeguarded during the period of preparation and implementation;
- the timeframe and remuneration for the creation of new Boards as a consequence of the separation and provider market development is clarified.