



# briefing

APRIL 2009

ISSUE 181

## The future for community services

Community services have been largely immune from some of the more far-reaching changes in the NHS over the last few years. Payment by results, new entrants to the market, and some structural and governance changes have been largely confined to the acute sector and to a lesser extent the mental health sector.

However, change is coming to the community sector in England over the next few years. A number of recent Department of Health (DH) policy documents present a challenging agenda for primary care trusts (PCTs) and their provider services.

This *briefing* outlines the main changes which will affect community services, refers readers to sources of more information, and gives the NHS Confederation's viewpoint on the changes.

### Key points

- Community services face significant changes to the way they are governed and funded over the next two to three years.
- The development of a quality framework will reduce variation and drive innovation.
- Over time, fewer services are likely to be directly provided by PCTs.
- More effective commissioning is a crucial part of transforming community services.

The 2008 NHS Next Stage Review emphasised the increasing importance in the future of services being provided close to the patient, and also underlined the need for services to develop and innovate. World-class commissioning is seen as the way to raise quality – but provider organisations also need to be fit for purpose to deliver the transformed services.

DH guidance issued since the NHS Next Stage Review has outlined a future where community services will adopt new governance models, where some services may be

opened up to competition, and where there will be more emphasis on contracting and understanding the quality and cost of services.

The Government is clear that the driver behind these changes is the desire to provide high-quality, responsive services, although value for the taxpayer also needs to be considered. The starting point for decisions should be the joint strategic needs assessment set out in PCTs' strategic commissioning plans – the form chosen for provider services should be guided by this assessment of needs.

*'By October 2009, PCT commissioners need to develop a detailed plan for transforming community services'*

### Key messages from the DH's vision for primary and community care

- Community services are critical to the delivery of improved services for patients and communities.
- There is much good practice but too much variation in quality and outcomes.
- Investment in staff and infrastructure is required to develop and deliver excellent out-of-hospital care.
- Clinical staff are central in driving change to improve quality, access and health outcomes.
- Staff need the business tools to support them to commission and provide high-quality community services.

### Quality

The NHS Next Stage Review set out the NHS's commitment to improving quality in community services just as in the acute sector. Changes in governance, structure and finance should support this drive rather than being an end in themselves.

The DH's overall quality framework stresses the role of clinicians as leaders in providing high-quality services, and improving access to

best practice through the National Institute for Health and Clinical Excellence developing and kite-marking quality guidelines. The DH is also producing a Community Quality Framework, focusing specifically on community services, to be published later this year. It is planned that this will capture high-level indicators to measure the quality of community services.

The NHS Institute has delivered the Productive Community Hospital programme, aimed at releasing staff time to care for patients and enabling provider organisations to compare their performance with others. Early indications are that adopting the programme can result in staff having 20 per cent extra time to spend with patients. The Institute is now developing the Productive Community Services programme which will be launched later this year.

Later this year, the DH is planning to publish a series of good practice guides setting out high impact changes aimed at clinical managers. They will cover the following areas:

- health improvement and health inequalities
- children and families
- long-term conditions
- acute care and specific treatments to be delivered close to home
- rehabilitation
- end of life.

#### Further information

*Developing NHS leadership: the role of the trust medical director.*

NHS Confed, April 2009.

*High-quality care for all.* NHS Confed briefing 168, July 2008.

*The Productive community hospital: releasing time to care.* The NHS Institute.

### Governance and provider form

PCTs should by now be in contractual relationships with their provider services, using the NHS Standard Contract for Community Services for 2009/10. They should also ensure there is internal separation between the commissioning and provider sides of a PCT.

This is, however, just the start of a more radical change for many provider services. By October 2009, PCT commissioners – working with practice-based commissioners – need to develop a detailed plan for transforming community services and to review the governance arrangements to assure themselves they have the best arrangements to suit local need. They should also publish a procurement plan.

It is envisaged that many PCTs will in time divest themselves of all or part of their provider services, allowing them to concentrate on becoming world-class commissioners.

By April 2010, PCTs should have agreed with strategic health authorities (SHAs) a strategy for the future of the community estate and throughout the year should be developing implementation plans. SHAs will monitor progress on these.

Options for organisational models include:

- a community foundation trust
- a social enterprise, covering all or part of the provider services – this may be driven by staff exercising a ‘right to request’
- integration with another NHS organisation – some PCTs are already looking at merging their community services to benefit from economies of scale, but other NHS organisations, such as mental health or acute trusts, could also take over the provision of community services (changes of this nature will have to be referred to the Co-operation and Competition Panel)
- a commercial organisation
- some services being provided by integrated care organisations and primary care
- partnership arrangements with a local authority, allowing joined-up health and social care provision
- continuing as a direct provider, and remaining part of the PCT.

The DH says that PCTs should look at the viability of each model and any associated risks “service by service, recognising that different options may suit different services.” This may raise concerns of fragmentation, with some services provided by social enterprises or commercial organisations while less attractive ones remain under direct provision.

The DH guidance is clear that there is no national blueprint for the future governance of provider services

but does emphasise the need for a robust process. While PCT boards decide what organisational form to adopt, they are expected to have regard to the views of SHAs. SHAs should refer back any proposals which are considered inappropriate or where governance or process is demonstrably weak.

There is no NHS trust option which would allow provider services to separate from their commissioning PCTs other than as a step towards community foundation trust status.

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There are currently six provider services in a DH pilot scheme to become foundation trusts; there is a limit to the number of further community foundation trust pilots which will be permitted.

PCTs which decide to maintain direct provision should periodically review

### Issues to consider

PCTs and their provider units will need to think about a number of issues as they move towards new organisational or governance models:

- **Who owns the assets such as buildings and existing equipment?** The DH says these should not normally transfer to providers as this may lessen the chances of competition. Commissioners should normally plan on the basis that providers will operate from commissioner-owned property.
- **Contracts to provide services will be for a fixed term, rather than open-ended.**
- **Staff will normally transfer to any new organisation under TUPE.** Existing staff will be able to continue paying into the NHS Pension Scheme in some organisational models, or get access to a “broadly comparable” scheme. PCTs are expected to meet high standards of workforce practice throughout the change process.
- **Engagement with the workforce and other key stakeholders is important.**
- **The ability to provide service and business continuity during changes needs to be assured.**
- **PCT provider staff may need a development programme to help them transform their services and compete in this new environment.**
- **The tax and VAT arrangements which will apply to the new organisation will vary according to form.**
- **PCTs should also consider the governance arrangements which will apply, especially during the transition period.**

*'A key change for NHS bodies will be the requirement to register with the CQC and meet standards for regulation'*

quality, viability and financial or sustainability risks. This process will be assured by the SHA which will also look at the reasons for retaining direct provision. Such direct provision is only an option when it is well-led, well-managed and more business-like, with effective schemes of delegated authority in place.

PCTs – both commissioning and provider sides – are now subject to the NHS performance regime which aims to identify underperformance, support recovery and manage failure. 'Challenged' PCTs could face management changes.

### Further information

*Transforming community services: enabling new patterns of provision.* DH, January 2009.

*Social enterprise, making a difference: a guide to the right to request.* DH, November 2008.

## Regulation

The regulation of healthcare providers is also changing with the advent of the Care Quality Commission (CQC), which has taken on the roles of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

A key change for NHS bodies, including PCT directly-provided services, will be the requirement

to register with the CQC and meet standards for registration; previously, only voluntary and private healthcare providers had to register. For 2009/10, NHS organisations will have to meet standards on controlling the risks posed by infection, but this registration framework will be expanded from 2010.

For 2009/10, any new private or voluntary healthcare providers will need to register with the CQC; this includes any social enterprises created as a result of changes to PCT provider organisations. Provider organisations which change but remain within the NHS – such as through a merger – should also check with the CQC whether they need to re-register.

All providers of healthcare should be aware that the requirements for registration will change from 2010, although the details of these requirements have yet to be finalised. A list of regulated activities will be published and any organisation providing these will need to register. Potentially, only a proportion of current PCT-provided services will fall under this.

### Further information

Changes to registration details, plus current requirements, will be at: [www.cqc.org.uk](http://www.cqc.org.uk)

## System management

Alongside structural change, the Government is keen to open up community services to new entrants and to provide improved patient choice. However, key decisions on this are being left to PCTs for local

determination, and there are no new national policies.

However, the Co-operation and Competition Panel will ensure that all parts of the NHS work within the Principles and Rules for Co-operation and Competition, and decisions about future options for community services need to be compliant with these rules. PCTs will need to demonstrate how they will enable patient choice and ensure fair competition between providers. Contracts for services may be for a fixed term rather than open-ended to allow periodic market testing.

One of the mechanisms likely to achieve greater competition in community services is the 'any willing PCT-accredited provider' (AWPP) model of PCTs accrediting more than one organisation to provide a particular service.

Commissioners should indicate which services are likely to be opened up to AWPP and in what timescale. They can include specific service and access requirements in any accreditation process. Anyone providing services under AWPP would not be guaranteed volumes of work. It is most likely to be used for services where there is a well-developed payment regime and there are no high start-up or fixed costs.

The Government is also committed to piloting individual budgets, with a view to rolling them out nationally should they prove successful. An individual budget is designed to provide individuals who currently receive services with greater choice

and control over their support arrangements. It is likely that individual budgets, if successful, would have an impact on the current model of community services.

PCTs should have a supply side strategy which balances the need for viable, high-quality services with the promotion of choice and innovation through new entrants. Horizontal or vertical integration with other NHS bodies could result in reduced competition and choice.

However, the NHS Next Stage Review highlighted the need for improved integration between health and care services to improve access to and quality of care. Integrated care pilots announced by the DH in April 2009 are designed to test new models of service delivery, looking beyond traditional boundaries – for example, between primary and secondary care – to explore whether new, integrated models can improve health and care services. A number of these pilots include community health services.

### Further information

*Transforming community services: enabling new patterns of provision.* DH, January 2009.

The Co-operation and Competition Panel: [www.ccpnl.org.uk](http://www.ccpnl.org.uk)  
Information on integrated care pilots: [www.dh.gov.uk/en/Healthcare/IntegratedCare/DH\\_091112](http://www.dh.gov.uk/en/Healthcare/IntegratedCare/DH_091112)

## Commissioning community services

More effective commissioning is a crucial part of transforming

community services. As part of the wider World Class Commissioning programme, the DH has published a resource pack for commissioners of community services. This sets out the challenges and provides examples of good practice in each of the core service areas of the Transforming Community Services programme.

From April 2009, most agreements between commissioners and providers – from both the NHS and independent sectors – should use the new standard NHS contracts. Exceptions include when an existing binding contract extends beyond April 2009; some contracts entered into by GP practices or consortia; cases where PCTs are contracting with other bodies; and when grants are used as an alternative to contracting.

Each contract contains three parts:

- mandatory elements which are effectively standard NHS terms and conditions
- required elements which are defined centrally and must be included but are completed by local agreement
- locally defined elements which can reflect local priorities, for example through incentive schemes, but must not undermine or contradict the other elements.

The contracts require commissioners and providers to link payment to quality improvement. From 2010/11, commissioners are expected to do this through commissioning for quality and innovation (CQUIN)

*'From April 2009, most agreements between commissioners and providers should use the new standard NHS contracts'*

schemes but for 2009/10 only they have the option of an agreed quality improvement plan as an alternative. Under CQUIN, PCTs will be able to commission for quality through making a part of payments conditional on quality and innovation. This allows local determination of appropriate quality indicators. Some schemes designed for the community sector have looked at areas such as care and compassion and the use of personalised care plans.

The standard contract also sets out processes for identifying and remedying performance problems and contract breach, and dispute resolution procedures.

Introducing the new contract, and reaching agreement with providers in a short timeframe, has been a challenge for PCTs. It is likely that work on aspects of it will continue throughout 2009/10 and that the standard contract will evolve over time.

It will be subject to feedback from PCTs and providers during its first year of implementation, and may change from April 2010. The NHS Confederation is working with the DH to further develop the model, with the aim that it should be an effective way of commissioning integrated health and social care services.

### Further information

*Transforming community services and world class commissioning – resource*

*'The funding system for community services will change radically over the next two years, towards one which rewards improvements in quality and value'*

*pack for commissioners of community services. DH, January 2009. The new standard NHS contracts. NHS Confed briefing 173, January 2009.*

## Introducing new pricing models for community services

Most community services continue to be funded through block contracts. This is in contrast with other parts of the NHS where more sophisticated methods of payment have been introduced, such as payment by results.

The DH has said that this system will change radically over the next two years as commissioners and providers move towards a payment system which rewards improvements in quality and value, ultimately improving health and well-being outcomes. This move will require a far better understanding, gained through improved information, of what the provision of a service actually costs.

Much of this work will take place locally, and decisions about which currencies (the units of healthcare for which a provider is funded) to use will be made at PCT level with SHAs assuring the process. But in two areas – child health promotion and end-of-life care – the DH will explore the potential for national currencies.

There is a range of currencies which could be used to determine pay for community services. At one extreme is a block budget which is not related to the number of patients; at the other is a system based on fees for individual services (such as payments for vaccinations). In between are systems based on capitation payments, payments for a year of care and payments per procedure or per day.

Each of these will create different incentives and will have implications for efficiency, quality and equity. The DH says that PCTs are strongly encouraged to develop currencies for most community services. However, it is likely that PCTs will have to prioritise certain areas rather than introduce the system across all services immediately.

Commissioners should consider which currency is likely to be most appropriate for each service and what they want to achieve. But they need to understand the patterns of risk and associated behaviours created by each currency.

Community services have not had good data and this needs to change to support currencies. The DH has been working on common data definitions which would aid benchmarking and comparisons of performance and quality. But much work on pricing will have to be done at local level through cooperation between commissioners and providers and an 'open book' approach. Lack of good data could undermine attempts to introduce currencies as they could lead to

unsustainable pricing models which either underprice or overprice services.

PCTs are urged to follow a seven-step plan to develop pricing options:

1. Prioritise service areas for currency and pricing development.
2. Document current service provision and associated costs.
3. Review national requirements for community services and current best practice.
4. Reconfigure community services portfolio and select currencies. This involves moving away from looking at groups of staff towards services provided for patients.
5. Price reconfigured services – including all elements such as staff costs, estates, diagnostic costs and indirect costs.
6. Implement the new model.
7. Examine the results.

### Further information

*Transforming community services: currency and pricing options for community services. DH, January 2009.*

## Confederation viewpoint

The NHS needs to be ready for changing demands on primary and community care over the next ten years, including:

- expectations of a more personalised health service
- advances in technology and treatments, which will mean

increasing numbers of people being treated in the community or at home

- demographic changes, which will see the number of people aged 85 and over double by 2029
- growing rates of obesity, which could mean rises in rates of heart disease and diabetes.

Community services are a major part of the NHS and they have a fundamental role to play in delivering the vision of the NHS Next Stage Review by providing responsive care based on what patients need, closer to home. But they have received little attention from policy makers in the past, resulting in low public awareness and leaving them of variable quality and failing to deliver their full potential.

There is an urgent need for the agreement of national standardised quality indicators for community services as for all other parts of the NHS. The lack of good quality measures will delay progress in shifting care from hospitals into the community, and any slow-down in the development of community services will make it

difficult to turn Professor Lord Ara Darzi's vision into reality.

Community services also lag behind much of the rest of the NHS in terms of IT and other infrastructure investment, and this must be addressed urgently.

While we welcome the guidance included in *Transforming community services*, the focus should be on improving care rather than on organisational form for its own sake. Too often in the past the NHS has focused on organisational change at the expense of quality improvement.

The vast majority of leaders of community services have told us they want to remain part of the NHS, with community foundation trusts (CFTs) often seen as the most attractive option. However, there is concern that the route map to achieve many of the organisational options is not clear.

There needs to be greater flexibility in the development of CFTs, with a lifting of the cap on the number of CFT pilots. The Monitor test for aspiring foundation trusts is already stringent and there is no need for community services to be treated

*'There needs to be greater flexibility in the development of community foundation trusts, with a lifting of the cap on the number of pilots'*

any differently to other aspiring foundation trusts.

Many community providers are considering mergers to achieve greater economies of scale, but the Co-operation and Competition Panel's view of this is untested.

There are unresolved issues in relation to the governance of PCT provider arms while they remain within the PCT – which is the likely case for most of these services for some time. We welcome the commitment made by the DH and the Appointments Commission to develop guidance, but we are concerned that this will not necessarily enable PCTs to put in place governance arrangements which are as robust as other parts of the NHS.

For more information on the issues covered in this *briefing*, contact [Elaine.Cohen@nhsconfed.org](mailto:Elaine.Cohen@nhsconfed.org)

### Further information

*NHS Next Stage Review: our vision for primary and community care.* DH, 2008.

*NHS Next Stage Review: a vision for primary and community care.* NHS Confederation briefing 169, July 2008.

*Community health services, making a difference to local communities.* NHS Confederation, 2009.

*Transforming community health services – putting staff at the heart of service development.* NHS Employers briefing 59, February 2009.

### The PCT Provider Services Forum

The PCT Network has established a PCT Provider Services Forum to ensure a strong, influential, national voice for community services and to enable the development and sharing of good practice. The Forum is led by leads of PCT provider services from each region and regularly holds national meetings for members on topical issues. [www.nhsconfed.org/Networks/PrimaryCareTrust/Pages/home.aspx](http://www.nhsconfed.org/Networks/PrimaryCareTrust/Pages/home.aspx)

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## The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.

For more information on the work of the PCT Network, visit [www.nhsconfed.org/primary-care-trusts](http://www.nhsconfed.org/primary-care-trusts)

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