Background

The debate about which organisational model to adopt for community provider services has repeated a common feature of policy in this area and paid more attention to structures and governance models than to the services provided to patients. Subsequent policy on PCT provider services has taken a ‘permissive’ stance, encouraging locally determined approaches to PCT provider functions.

Key points

- Models of service delivery will include contractor-based, vertically integrated and geographically integrated provision, and partnership models.
- Partnership models to be explored include those with social care and local authorities, with the independent and voluntary sectors, and between independent clinicians.
- Organisational forms which would support service delivery include social enterprises and community foundation trusts.
- Wholesale change often leads to a drop in performance, so PCTs should prioritise and phase service changes to fit with overall strategic plans.

The response to the Commissioning a patient-led NHS letter of July 2005, proposing a clearer split between commissioning and provider functions at the level of the primary care trust (PCT), started the debate about which organisational model to adopt for community provider services. This Leading edge briefing looks at questions concerning the most appropriate type of model: which sector does the service fit into; what type of organisational design is needed; and what sort of organisational form will achieve this?

This is the second of a series of three briefings looking at the future shape of service provision in primary care and community settings in light of the health reform agenda.

The first paper in this series of Leading edge briefings – First steps in planning primary care trust provision – looked at the issues that need to be understood by commissioners and potential providers before any consideration can be given to governance models, ownership, type of organisation or other structural issues. These questions included:

- Is there a clear commissioning strategy?
- Do you know who your customers are?
Local government
Much has been written about the opportunities to integrate health and social care, although the number of care trusts providing fully integrated adult health and social care services is still small. Of wider interest, however, are children’s trusts which may commission, provide or jointly deliver both types of functions, overseen through local children and young people’s strategic partnerships.

Children’s trusts have been allowed to develop in different ways to meet local needs, so their models are diverse, although in some areas they are still works in progress. As they use the local strategic partnership mechanism to deliver their governance arrangements, their relationships are to both health and social care, with the overview and scrutiny committee demonstrating local democratic accountability. It is therefore pertinent to consider the range of models already in existence when debating this option.

The independent sector
The independent sector is already established in providing a range of community-based specialist services and these providers may be well placed to extend their range of provision.

Which sector does the service fit into?
To answer this question the extent and type of the organisational change needed should be clarified. The nature of the change should be built around specifying future service models, which fall out of the agreed care pathway and are designed to deliver real patient benefits. The providers may be:

- for profit, NHS ‘family’ – GP practices, optometrists, community pharmacists, dentists
- not for profit, NHS family – existing NHS trusts, foundation trusts and PCT providers
- for profit, external to NHS – independent sector treatment centres (ISTCs), commuter walk-in centres, alternative provider medical services (APMS) providers
- not for profit, external to NHS – third sector providers, social enterprises, joint services with local authorities, care trusts, children’s trusts.

Key Design principles for out-of-hospital care
- solutions must be locally determined
- patient time is not free and patients need to be in control and supported to self-care
- integration and continuity matter and organised systems of care need to be created
- services should not exist if they don’t provide value to patients
- technology should be used to make care delivery more effective
- patients should see the most appropriate professional
- new ways need to be developed to involve patients and the public.
What sort of organisation for PCT provider functions?

The Third Sector Taskforce has highlighted the need to support market entry and development and understand the value added by third sector providers both in the enhancement of health needs intelligence and service provision. The introduction of consortia of providers, including both national and niche organisations, should further strengthen the sector’s ability to respond to the new contracting environment.

What sort of organisational design is needed?

There will be several different models of service delivery, the most developed of which are outlined below.

Contractor-based provision (directly managed or arms-length)

General practices already provide a range of services directly to their population. However, where GPs are already collaborating in clusters which cover a significant population for practice-based commissioning, there is potential for these clusters to expand into wider areas of service provision. Generic services such as community nursing and therapy services could be provided directly by GPs working through a consortium or joint venture arrangement. The use of a variety of contract types, for example APMS or specialist provider medical services (SPMS), may enable a greater consistency of approach, for instance in areas which have been traditionally under-doctored. Other contractors, particularly pharmacists, may also extend the number and range of professionals working around specialist service areas and the scope of services offered, for example coronary heart disease monitoring and health promotion. Care will be needed to ensure governance arrangements are adequate as the licensing of contractor-based services will not, at present, be covered by the proposed arrangements set out in the Systems Management and Regulation Framework, currently under consultation.

Contractor-based provision

Why do it?

• care is integrated out of hospital with improved teamwork at practice level
• shared intelligence of health needs can give a more accurate picture for commissioning purposes
• coordinated services ensure that the right professional can be seen at the right time
• provides a strong, clinically-led care model.

Why not?

• a dual role where the practice is commissioning its own provided services may give rise to probity issues
• poor economies of scale may exist where individual practices provide small services on a practice population basis
• potential governance issues where practices work in clusters
• different staff cultures between community and practice-based staff may cause tensions in the development phase.

Vertically integrated provision

Vertical integration between secondary and primary care organisations, or some elements of provision in each, enables some of the historical interface issues to be resolved and care pathway approaches to be strengthened. Specialist models may include integrating consultants appointed to work in both the PCT and the hospital trust, or a hospital trust holding contracts for consultants working within a PCT in order to help with recruitment or Royal College accreditation.

Vertically integrated provision

Why do it?

• services can be brought together along a care pathway
• overcomes some of the perverse incentives of tariff, for example hospital admissions for non-elective care
• clinical engagement and integration can occur across both community and secondary care
• efficiency and productivity can be improved across a pathway, leading to more consistency
• infrastructure costs can be reduced by sharing back office functions.
why not?  
- economies of scale may be hard to achieve where services are specialised  
- conflicting capital needs may arise between hospital and community services  
- cultural differences may be a major issue  
- community services may lose out if the integration is driven by secondary care.

**Geographically integrated provision**  
One of the fundamental problems of the development of PCT-based provision following *Shifting the balance of power* was the loss of economies of scale and scope which followed the splitting of services traditionally based within community trusts. Different PCTs dealt with the issue in different ways, leading to inconsistent and potentially fragmented delivery systems which addressed population needs to a greater or lesser extent. Geographically integrated provision has the potential to rediscover some of those economies that were previously difficult to attain, either through the pooling of services directed managed across the PCT, their development as part of SPMS or a public interest company, or through new organisational forms such as community foundation trusts.

**Why do it?**  
- culturally acceptable for existing community staff  
- levels of public involvement in out-of-hospital services enhanced through membership  
- gives economies of scale to primary care services if aggregated across several PCTs.

**Why not?**  
- no integration with practice staff or social care unless under SPMS  
- management may need to be strengthened to deal with the requirements of foundation trust status  
- model may be managerially and not clinically led.

**Partnership models**  
Several different types of partnership model could be explored. These are detailed below.

**Partnerships with social care and local authorities**  
**Why do it?**  
- positive for joined-up agendas, for example health improvement, well-being and children’s services  
- gives a locally shared vision of care out of hospital  
- strengthens the use of pooled budgets, co-location and strategic planning, for example children and young people’s plans, sustainable communities strategies

"Children’s trusts have enabled integrated services to be delivered in new, community-based settings"
Partnerships with the independent and voluntary sectors

Partnerships between the independent sector and NHS providers can enable new money to flow into services, particularly capital resources or set-up costs for particularly innovative areas of work. They also enable scarce specialist skills to be distributed more widely across providers whilst bringing the best of NHS and independent sector expertise together. Similarly, joint ventures with third sector organisations could enhance the reach and responsiveness of some existing services.

**Independent sector**

**Why do it?**
- brings in financial investment and business acumen, and some skills not available within existing NHS management structures
- good for innovation and transformational service changes
- maintains existing staff within the NHS whilst building in independent sector expertise.

**Why not?**
- cultural issues may be exposed
- potential for ‘cherry-picking’ more lucrative elements of services
- regulation and governance arrangements may be complex.

**Third sector**

**Why do it?**
- social enterprise culture is consistent with the NHS
- brings in good consultation mechanisms and health needs intelligence
- increases ‘reach’ into some population groups

**Why not?**
- cultural issues may be exposed
- potential for ‘cherry-picking’ more lucrative elements of services
- regulation and governance arrangements may be complex.

Partnerships between independent clinicians

The chambers model places consultants or other medical practitioners and clinicians at arm’s length from the organisations providing services and enables them to contract with several organisations at the same time, so supporting pathway approaches which cross traditional boundaries. Whilst the members mostly act independently of each other in chambers, in collaboratives this is taken further as clinicians cooperate to deliver clinically-driven care models. A version of the collaborative model may be that of services delivered through consortia of local GP practices as described above (see page 3). There is also the opportunity...
What sort of organisation for PCT provider functions?

It seems natural to extend the freedoms of foundation trust status to other areas of provision

to separate infrastructure and asset management from clinical services in these models, so freeing up clinical time which would otherwise have been spent in non-clinical management tasks.

Partnerships between independent clinicians

Why do it?
- continuity maintained across organisational interfaces
- gives clinical leadership to service development
- is network-based and therefore fits with new care pathway approaches
- the asset and administrative base is managed separately, so reducing administrative burdens on senior clinicians.

Why not?
- public involvement is dissociated from clinical decision-making
- potential market in senior staff may affect viability of services.

What organisational form is needed?

There are several organisational forms which would support any of the above models. In some cases, where services are maintained within the PCT, separate reporting and governance structures will be necessary to ensure probity. For services hosted outside PCTs, existing NHS forms, such as hospital trusts, foundation trusts, local authority structures (particularly building on children’s trusts and/or connected care arrangements) or commercial organisations (in the case of independent sector-provided services), obviously form a proportion of the structural forms that will be necessary. Each will continue with its existing governance and accountability structures, some expanded through LSP and LAA arrangements, board requirements and, in some cases, shareholder engagement mechanisms.

However, much has also been written about the potential for social enterprises, of which third sector bodies are usually examples, to deliver benefits that are elusive within the NHS. It should be remembered that models such as foundation trusts are also implicitly social enterprises given their membership arrangements and the investment of profits back into the business for the benefit of their local population.

Social enterprises

A social enterprise is defined as a business with primarily social objectives whose surpluses are principally re-invested in the business or in the community for that purpose, rather than a business driven by the need to maximise profit for shareholders and owners.

Social enterprises can take different legal forms, including companies limited by guarantee, companies limited by share, industrial and provident societies (also known as community benefit organisations or cooperatives), registered charities and community interest companies.

Social enterprises need to ensure they involve their local community and staff in their decision-making processes and, in the case of some forms such as community benefit organisations, ensure shareholding is encouraged for members. The different types of social enterprise can change their form as their business changes. Hence a community interest company can become a charity, with the different fiscal advantages and governance arrangements that this entails, or vice versa. The splitting of existing functions into different forms can also be advantageous in some cases. For example, some practices are considering splitting their commissioning and provider functions into two separate companies, one limited by share and one by guarantee, to spread the risk as they broaden the range of services offered.

Community foundation trusts

The foundation trust model has already shown demonstrable success in improving the standards of provision in the acute and mental health sectors. It seems only natural, therefore, to extend the freedoms of
Although there have been discussions with ambulance trusts, NHS Direct and others, the focus of the work of the Department of Health and Monitor to date has been on adapting the mental health model for community provision. A group of PCTs has already begun to scope this as a serious option. However, it is important to remember that the Department of Health is also considering other governance models for community provision, including social enterprise models and in-house models as variations on the status quo.

**Community foundation trust model**

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<th>Why do it?</th>
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<tr>
<td>• increased levels of autonomy and scrutiny</td>
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<td>• enables choice and contestability</td>
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<td>• staff remain part of NHS family</td>
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<td>• patients are better engaged through governance arrangements.</td>
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<th>Why not?</th>
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<tr>
<td>• complex process of assessment</td>
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<td>• capacity of existing PCT senior managers to do this whilst developing commissioning organisations at the same time</td>
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<td>• cost implications of shadow organisation</td>
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<td>• dependent on gaining contracts and may not be viable in the long term</td>
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**Practical considerations**

It is important for PCTs to remember the lessons of past service changes. The evidence suggests that wholesale change frequently leads to a drop in performance, particularly for the first couple of years, as effort is diverted from the core business into creating new organisational structures and culture. This underlines the importance of making a robust case for change which can realistically expect to deliver improvements to services, and prioritising and phasing some of the service changes to fit with the overall strategic plan of the local health and social care community.

Recent work with the Local Government Association, whose members went through a similar split of commissioning and provision during the 1990s, has shown that high performing local authorities can have very different provider functions ten years later. In some cases almost all provision is outsourced through contract, in others it is provided by directly employed services. At a recent seminar on the learning from these reconfigurations, the key message was that a set of core principles, rather than a single way, should be followed. These principles were:

- effort and emphasis is needed to develop the core commissioning focus of the organisation – where service delivery is the core of the culture of the organisation, this can hamper development of this focus
- there has to be a cultural shift to competent commissioning – reallocation and strengthening of the commissioning resource is central to the success of commissioning in the long term
- alliances need to be built to deliver quality services – managing the market requires new partnerships to be built and new ways of service delivery explored
- commissioning knowledge needs to be developed
- risk and innovation have to be actively managed – this was cited as both a reason for outsourcing and a key feature of in-house services. Again, there is no single right model for managing risk or ensuring that innovation is present within provider functions.

Great importance was placed on how achieving these principles impacts on services being provided directly by the authority and on the effort required to reconcile the move towards a commissioning mindset with the provision of high-quality services.

Moving services to new providers is rarely cost neutral, and PCTs will need to consider what they can afford, alongside the issue of how much change they can sustain. Past experience of service moves shows that it is often hard to extract the full cost of support services from the parent organisation, particularly if
there are already shared service arrangements in place. This may be less important if the service is moving to an existing large provider which already has a good infrastructure in place, compared with a move to a new or smaller organisation.

Whether staff move to the new provider or not, organisations may face a loss of continuity and organisational memory for which planning will need to be in place.

Conclusion

The process of determining the future of out-of-hospital services needs to end with a consideration of organisational form, governance and ownership, not start with it.

Commissioning community services is perhaps one of the most important things that PCTs have to do, and yet an understanding of what these services do and how they perform may be hampered by poor quality data. The third paper in this series will consider the commissioning issues around community services and the lessons that could be learnt from the experience of local authorities.

The ideas in this briefing are intended to start a challenging debate. Readers may disagree with its arguments or have suggestions for how they could be further developed. Your comments are welcomed. Please send them to elaine.cohen@nhsconfed.org

Further information

Design principles for out-of-hospital care.
NHS Confederation Leading edge briefing issue 11, November 2005

First steps in planning primary care trust provision.
NHS Confederation Leading edge briefing issue 20, November 2006
www.nhsconfed.org/publications

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