Transfer and transform
The challenges for community health services

Key points

• Plans are underway to transfer community service provision from PCTs by April 2011. Much of the work needs to be complete by the end of 2010.
• The main aim should be to transform services for patients and it is important not to lose sight of this in the complex transfer process.
• Attention needs to be paid to board membership and revised governance arrangements.
• Considerable leadership effort and skills are needed to ensure synergy between the different cultures involved in the merged organisation.

Community health services cover ‘cradle to grave’ services that many of us take for granted. They provide a wide range of care, from supporting patients to manage long-term conditions like respiratory disease and diabetes, to treating those who are seriously ill with complex conditions. In addition to treating patients in their own homes, they also provide a range of preventative and health improvement services, often with a range of partners from local government and the third sector. At some point in their lives most people will have contact with these services.

Plans are underway to transfer community service provision from primary care trusts (PCTs) by April 2011. The presence of these services in the community and their close day-to-day working relationships with GPs means they are well placed to deliver the improvements that sit at the heart of the Government’s planned NHS reforms.

This Briefing sets out the key points from our discussions with members who have experience of transferring services, including their learning about how best to transfer services, what exactly should be transferred, the cultural issues to consider and the necessary governance arrangements.

Background

Community-based care is popular with patients and, as the latest policy vision is implemented to transfer community service provision from PCTs by April 2011, it will be important to preserve the features of coordination, continuity and care that make it special.

In July 2010 the PCT Network met with members of the Community Services Forum, the Mental
The CRC Energy Efficiency Scheme and the NHS: what you need to know and do

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Health Network and the NHS Confederation, including acute trusts and foundation trusts. The discussions focused on the issues surrounding the separation of community services from PCTs and transferring them to new organisational forms, and the challenge of keeping the focus on service transformation.

Those working in or with community services will be familiar with the themes in this Briefing, but the transfer of services from April 2011 means that many people will come into contact with the differences inherent in these services for the first time. This Briefing highlights the key issues for managers and non-executive directors whose organisations face substantial change as a result of planned mergers with local community services.

Key facts

Community health services, along with primary care, form the bedrock of services in the NHS. Ninety per cent of contacts between health professionals and patients occur in these settings.

Community services are provided by some 250,000 staff, the majority of whom are employed by PCTs.

The annual expenditure of community health services is £11 billion.

Community services are an essential part of the drive towards delivering more personalised care, closer to home.

The Revised NHS Operating Framework stipulates that proposals for the future of community services currently managed by PCTs should be capable of being implemented, or substantial progress made towards implementation, by April 2011. The main types of organisation that could deliver these services are:

- NHS acute trusts
- NHS foundation trusts
- NHS mental health trusts
- NHS community foundation trusts
- social enterprises
- the independent sector.

The Community Services Forum

The PCT Network hosts a Community Services Forum to ensure a strong and influential national voice for community services and to enable the development and sharing of good practice.

More importantly, the forum wishes to ensure that the momentum around the transformation of services is not lost during the current period of structural change.

Community services policy

After many years in the policy ‘desert’, community services became the focus of the Transforming Community Services programme initiated by the previous government. The sector welcomed this attention, but national debate about the organisational form of community services, and changing requirements about the timetable for separation from PCTs, has taken the focus away from the transformation agenda.

The Revised Operating Framework of June 2010 and the Equity and excellence: liberating the NHS white paper of July 2010 have clarified both the timetable and requirements for PCTs and their provider services. The Revised Operating Framework states:

“Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured. PCTs should therefore continue to develop and review proposals for the divestment of their directly-provided community services.”
This sets a challenging timetable for many PCTs where the new policy has resulted in a reappraisal of their original proposals.

However, the expanded number of options, especially for those seeking to become community foundation trusts or social enterprises, may result in a more locally appropriate option.

There is a wealth of research and evidence on the pros and cons of integrating community services, including a report by the NHS Confederation. More recently, the Nuffield Trust has published a series of papers on integrating NHS care.

Transferring services

Tight timescales

The timescales set out in the Revised Operating Framework are extremely challenging, even for those services with well-developed plans. PCTs undertaking a reappraisal of their original proposals will find themselves under considerable pressure to meet the April 2011 deadline.

The requirement of implementation by April 2011 means that much of the work will need to be completed by the end of 2010. There is some risk of making decisions in order to fit the timetable rather than making the right decision.

Complexity

The members we spoke to warned against underestimating the complexity of the necessary ‘corporate transactions’ when transferring services. Each of the processes can take months to complete, and information to support them may not be easily accessible. This applies equally to services establishing a new community foundation trust or social enterprise, as well as those transferring to an existing NHS trust. Guidance from Monitor outlines the process and requirements and provides an indicative timetable for the review process. Transactions which are more than 25 per cent of the income of a foundation trust are deemed to be ‘significant’ and the indicative timetable is three months. It also states that approval from the Co-operation and Competition Panel (CCP) needs to be in place prior to any transaction. Although the CCP has introduced a fast-track process, it will not be applicable to all proposals.

Points to consider when transferring services

Where possible, consider running the processes we outline here in parallel, taking into account:

- the need for both the transferring and receiving organisation to be willing to invest time and resources
- due diligence – the importance of gathering and reviewing the necessary information
- regulation issues – the merged organisation will need to amend its registration with the Care Quality Commission to take account of new services and sites
- local authority overview and scrutiny committees will need to support the proposed new arrangements
- the Co-operation and Competition Panel (CCP) – talk to them early. Understand if your reconfiguration is eligible for the fast-track process; if there are issues around the 30-day rule you may not be. If you don’t provide the information they require it can torpedo your timelines. For more information on early experiences of working with the CCP see Learning from the first wave of CCP merger reviews
- Monitor – receiving trusts that are not foundation trusts will need to ascertain the potential for any delay in their application for foundation trust status.

The white paper and subsequent letter from NHS chief executive David Nicholson set out the revised requirements for service reconfiguration, which are:

- support from GP commissioners
- strengthened public and patient engagement
- clarity of the clinical evidence base
- consistency with current and prospective patient choice.
The complexity of community services themselves should not be underestimated. Unlike other types of service, there is no common template for these services. It is fair to say that no two community services provide the same range of services in the same configuration. It is common for community services to provide as many as 70 separate services.

What to transfer and where
As well as considering the processes required to ensure a smooth transfer, there needs to be an understanding of which elements of the service are transferring and their state of business readiness. For each service, consider its business readiness. If it is not ready to be transferred, what will happen to that particular service?

Despite the NHS Standard Contract for Community Services, we have heard of misunderstandings about expectations of what services are to be (or not to be) provided. Many elements of community services are still commissioned on a block contract basis, with variable levels of contract specification and information on activity and/or outcome.

Policymakers still need to resolve the issue of transferring estates. Phasing out PCTs from April 2013 means commissioners are unlikely to be able to own buildings, which raises questions about the NHS local improvement finance trust (LIFT) scheme. Community estates are as wide-ranging as the services themselves. Some are state-of-the-art new buildings (with or without expensive LIFT and PFI schemes) but many are old, crumbling and not fit for purpose.

Information systems present another challenge. Systems may not be universal across all of the services in the community, and may not interface with systems in the trust that services are being transferred to.

Practical suggestions for integrating community services

- Appoint joint posts as soon as you can.
- Be properly pragmatic – transfer services as they are, but plan to integrate within six to 12 months.
- Change takes longer than you think – identify champions to help you get key messages across.
- Work to develop trust with middle managers.

Transforming services is the main aim
In the flurry of activity surrounding the process of setting up new community organisations or transferring services to one or more existing organisations, it is important not to lose sight of the underlying reason for undertaking these changes.

The point of all these transactions is to transform services to improve quality, patient experience and efficiency. Transferring services without the accompanying transformation, even if not immediately, is a waste of time, effort and considerable resources.

Changing cultures
Integrating and transforming services that do not naturally feel a synergy with each other or, as in some circumstances, have until recently viewed each other as competitors, will require considerable leadership effort and skills. One of the organisations we talked to had recently merged community services with acute services and said each side sees the other as the root of all its problems. The easy option would be to simply add the community services to an existing management structure as an additional ‘division’, but a more integral approach is needed for the service to be transformed.

A bolt-on service is not the answer
Everyone who contributed to this Briefing agreed that simply ‘bolting on’ community services as another division is not the right way forward. Doing this is unlikely to contribute towards the Quality, Innovation, Prevention and Productivity (QIPP) agenda and will not take advantage of potential synergies in the merged services. They also pointed out that services are not necessarily cheaper if provided in the community.

The scale of many mergers, especially where large community services are planning to merge with mental health trusts, can mean that the ‘receiving’ trust more than doubles its size and
the organisational concept needs to change. For example, see the Oxleas case study below. Many will now have to consider what type of trust they are – various terms are being used including ‘community well-being trust’ and ‘integrated community health services provider’. Some organisations are adopting a new name to reflect their new role.

**Board membership and governance**
To avoid the bolt-on scenario, consideration needs to be given to the role of executives and non-executives from community services. The experience of some merged services is that the necessary understanding of and skills to manage the new services have not been reflected at board level. The consequence of this appears to be that very little transformation or integration of services has occurred, and they continue to operate much as they did under their previous management structure.

Where mergers are of (almost) equal-sized organisations, a more transformational solution would be to develop structures that change the status quo to ensure that the leadership reflects the redesign of services. Similar consideration will need to be given to any membership arrangements.

Community services staff work as decentralised autonomous clinical professionals. They are used to controlling their own working day and receive less oversight than colleagues in other settings. This way of working presents a different set of challenges for board assurance than where the workforce is always on site.

**Beyond 2011: any willing provider**
April 2011 is the target date for the transfer of services from PCTs but it won’t be the end of the story. The coalition Government’s support for social enterprise and employee ownership models in public services, including healthcare, is likely to allow smaller, discrete community services to separate and establish themselves as stand-alone organisations under the ‘any willing provider’ policy. For example, a number of Improving Access to Psychological Therapies (IAPT) sites have been approved to establish themselves as social enterprises.

The ‘any willing provider’ approach to community services may pose threats to newly established or merged community services.

**Case study: Oxleas NHS Foundation Trust**
Oxleas is a foundation trust which provided mental health and learning disability services in south east London. It merged with Bexley Community Services in July 2010 and plans a further merger with Greenwich Community Services in April 2011. The mergers will create a new integrated community health organisation with:

- a 60 per cent increase in workforce (an additional 1,200 staff)
- 40 additional locations
- a £55 million (40 per cent) increase in budget.

The trust aims to remove the divide between the delivery of physical and mental healthcare and provide a continued focus on care closer to home. Through developing innovative models of care, Oxleas will support the shift to out-of-hospital care within the local community.

**New relationships**

**Wide range of partners**
Services have a complex set of relationships with a wide range of partners and it is important that these are not lost when services are transferred. These are likely to be different to the relationships that receiving trusts are used to dealing with. These relationships may be ‘invisible’ to others (including patients) but they form the ‘glue’ in the system that allows patients to transfer to and from acute care, social care and primary care.
‘We are concerned that those that have yet to fully agree future options will not be able to complete them in six months’

Although PCTs commission most community services, referrals into the service will be from a number of sources. As well as GP practices these are likely to include:

- acute trusts
- mental health trusts
- social services:
  - children’s centres, SureStart, education, intermediate care
- police and safer communities partnerships
- voluntary and third sector organisations.

There are also a wider range of partners involved in the delivery of community services, including all of the above, and other local authority departments (leisure, transport, libraries and education).

**GPs and social services**

As well as developing relationships with existing partners in community services, the proposed move towards GP commissioning presents a new challenge.

GP consortia are in an embryonic state, and their final shape and size is not yet clear. It is likely that merged trusts will have to relate to several consortia.

Community services staff have a complex relationship with local GPs. Many practices consider community front-line staff as ‘theirs’ and will want to have a personal say in any proposed changes to current arrangements.

The other major partners in community services are social services. Staff often work hand in hand with social care staff and in many cases are able to directly commission packages of care. Over recent years community services have worked to integrate with social care and many joint posts have been appointed. However, the complexity of legal barriers has inhibited full-scale integration. It is essential that these relationships are not diminished or lost as community services move into new arrangements. Local authorities will need to be reassured that services will not be drawn into trusts rather than continue to be out in the community.

Relationships with sectors outside of NHS services will also need to be maintained and developed. Many services rely on working in partnership with the voluntary and third sector. These may range from large national organisations to smaller niche providers.

**PCT Network viewpoint**

The focus of this Briefing is on transferring and transforming community services and we know that dealing with the complex issues surrounding the transfer will be at the forefront of managers’ minds for the remainder of 2010/11. Those whose implementation plans have been underway for some time should meet the deadline of April 2011. However, we are concerned that those that have yet to fully agree future options will not be able to complete them in six months.

We welcome the emphasis on the transformation of community services. There is strong evidence that integrated care can be an effective way of delivering healthcare. It offers opportunities to break free from the stranglehold of the division between primary and secondary care that has constrained innovative thinking in the past. The evidence also suggests that approaches which focus on integration around the patient pathway are more likely to be successful than those which involve the wholesale transfer of functions from other organisations. Carving out particular disease groups and contracting care out to specialist providers should also be avoided, and close collaboration with primary care is important in all cases.

As we said in our Building integrated care report in 2005, the unwary face a number of pitfalls, of which the most common are over-optimism about timescales and potential results, misjudging the dangers of unrelated diversification, and underestimating the importance and difficulty of the cultural issues and management of change.

The complexity and size of issues needing to be resolved in completing the transfer of community services away from PCTs is significant and the requirement to complete this by
April 2011 increases pressure to focus on process issues.

In the midst of this structural change, services still need to deliver management and QIPP savings. Unless the focus remains firmly on transformation, all that will be delivered is yet another expensive NHS reorganisation.

If transformation is to be delivered, the whole of the new organisation will have to ensure that clinical pathways are reviewed to ensure maximum gain is achieved from synergies between services.

A range of new relationships will need nurturing, which will require considerable time and effort.

Proposed new commissioning arrangements with GP consortia and local authorities will require significant attention and cannot afford to be ignored.

We await resolution and clarification from the Department of Health about a number of policy and practical issues, particularly guidance on the transfer of estates and assets.

The Government’s proposals (Equity and excellence: liberating the NHS white paper) for how services are provided could transform NHS provision from a managed system to a regulated market on the model of the regulated utilities. A major shift in understanding will be needed about how providers will operate under regulatory rather than direct government control and we await with interest clarification about the ‘any willing provider’ policy for community services referred to in the white paper.

For more information about the issues covered in this Briefing, please contact Elaine Cohen, Senior Policy Manager, at elaine.cohen@nhsconfed.org

References

4 Learning from the first wave of CCP merger reviews. PCT Network, August 2010.
5 DH Gateway reference 14543, 29 July 2010.
The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. The Network aims 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.

For more information, contact pctn@nhsconfed.org or visit www.nhsconfed.org/pctn

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