Department of Health

Transforming Community Services

The assurance and approvals process for PCT-provided community services

NHS

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Cross Reference	Transforming Community Services: Enabling New Patterns of provision
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Action Required	PCTs to take into account national assurance and approvals process, including assurance tests set out within this guidance.
Timing	**By 31 March 2010**
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Transforming Community Services

The assurance and approvals process for PCT-provided community services

Contents

1. Introduction

Purpose

1.1 This guidance aims to support:

> PCTs as they develop proposals for the future shape of their community services.

> SHAs in their role to assure and approve PCT proposals for the future shape of their community services.

It has been co-produced with SHA Transforming Community Services (TCS) and System Management leads.

Background

1.2 *Enabling new patterns of provision*[1] provided support to PCTs to make decisions on future arrangements for the provision of community services that best meet the needs of service users, their carers and families and local communities. It also provided advice on different types of organisational form and on how to manage the change to support service transformation, ensuring effective and early staff and union engagement and good workforce practice, including the application of the Staff Passport.[2]

1.3 In a speech to the NHS Confederation on 6 October 2009, the NHS Chief Executive, David Nicholson, made the case for service transformation: "Transforming community services is a really important part of high quality care for all. Many of our service users, their carers and families only experience community services and they make such a big difference for their health and wellbeing. ...community services are absolutely pivotal to taking forward the whole agenda of quality, innovation, productivity and prevention."

1.4 *NHS 2010–2015: from good to great. preventative, people-centred, productive*[3] set out a vision for an NHS that is organised around patients, whether at home, in a community setting or in hospital. Paragraph 4.44 states: "We will greatly increase the integration of services by doing much more to shape them around patients and to ensure that the boundaries between organisations do not fragment care. Community services will be a particular priority, since they have a pivotal role to play in realising our vision for more integrated, efficient and people-centred care".

1 *Enabling new patterns of provision*, Department of Health, January 2009

2 See Appendix 2 of *Enabling new patterns of provision*

3 *NHS 2010–2015: from good to great. preventative, people-centred, productive*. Department of Health, December 2009

NHS Operating Framework 2010/11

1.5 The NHS Operating Framework 2010/11[4] has set the following requirement:

> **'by 31 March 2010**
>
> PCTs must have agreed with SHAs proposals for the future organisational structure of all current PCT-provided community services.'
>
> For the avoidance of doubt, "agreed with SHAs" means that PCTs should have secured *approval in principle* from SHAs for proposals for the future *organisational form* of their directly-provided community services.

1.6 The reasons for setting this timescale are that:

- Community services play a crucial role in helping the NHS to meet the productivity and quality challenge.
- The NHS needs to achieve an unprecedented transfer of care and treatment from hospital to community settings and community services have a pivotal role to play in this.
- This transformation cannot take place without more stable, sustainable organisational foundations to support staff.
- It also means accelerating service integration – community with primary, secondary, social care and children's services. This cannot be achieved without high-performing organisations with enabling cultures.

1.7 The deadline of **31 March 2010** for the approval in principle of organisational form has therefore been set to accelerate the pace of transformation of community services and provide greater certainty for staff. This gives PCT providers a full year to prepare to meet the challenges set out in *NHS 2010–2015: from good to great. preventative, people-centred, productive*. It is important that early and effective staff and trade union engagement in developing proposals remains an integral part of the process in this accelerated timetable. Failure to engage could jeopardise the success of the proposals.[5]

1.8 Implementation of any new provider form will therefore need to be completed by 31 March 2011, or very substantial progress to have been made towards the new organisational form, meeting the milestones agreed on approval with the SHA towards final implementation.

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4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107 See para 3.71 p.42

5 *Enabling new patterns of provision,* Appendix 2, page 76, paragraph A58

2. Organisational forms

2.1 To meet the quality and productivity challenge, the NHS Operating Framework 2010/11 has given a clear steer on the options available to PCTs. There remains no prescribed form, but proposals will be subject to a nationally defined assurance process against a set of tests that this document provides. These are set out in Section 3 of this document.

2.2 The assurance process will support PCTs to innovate locally, to create a system that best meets local needs whilst at the same time ensuring that community services are delivered by organisations that are fit for purpose and able to respond to the quality and productivity challenges ahead.

Options for organisational forms

2.3 The list of organisational forms is not exhaustive. Different forms will suit different services, and innovative hybrid organisations derived from more standard original bodies may emerge. PCTs should consider options which achieve the best match for individual services with local commissioning priorities (based on health need and local people's views) whilst meeting the national tests for quality, efficiency and sustainability. Services differ in the characteristics and the people they serve, and therefore different forms and different providers may suit different services, even within the same area.

2.4 The most likely options are set out below; fuller information on each is available in *Enabling new patterns of provision*[6]*:*

> Integration with an NHS acute or mental health provider

> Integration with another community-based provider

> Social Enterprise.

Also options, but not expected to be the norm:

> Community Foundation Trust

> Continued PCT direct provision

> Care Trust which includes provision.

} where partnered by strong commissioning

Integration

2.5 By integration, we mean the single management of services to promote innovation, provide better quality and experience of care for individuals, and improve the efficiency of service

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delivery. This can include health and social care services, and hospital, community and primary care services, acting together to maintain and improve individuals' health and wellbeing. It also means organising services around the needs of individuals to reduce unnecessary hospital visits, or admissions into residential care, or reduce the length of time people spend in hospital by supporting people at home, ensuring that boundaries between different providers do not fragment care for the individual. Joining up commissioning and provision to provide individual care pathways – such as dementia care pathways – can help improve outcomes. Providing this integration or coordination will be particularly important where people have multiple needs across different care pathways.

2.6 For children, service pathways will need to cover not only the interface between hospitals and community services but also the interface with early years services and schools, as well as with children's social care. The interface between child and adolescent mental health services and other services for children and young people, including those moving into adult services, will also be important.

2.7 Where PCTs decide that integration can best be achieved through a new organisational form, proposals must be compliant with the requirements of the *Principles and Rules for Cooperation and Competition*. We are working with the Cooperation and Competition Panel to streamline the approvals process for proposals that need to be referred to them.

Integration with an NHS acute or mental health provider

2.8 Forms which bring community services together with NHS hospital or mental health services may provide a focus on admissions prevention and integrated pathways, particularly for patients with long-term conditions or those requiring intermediate care services.

Integration with another community-based provider

2.9 PCTs may decide that some community services would be better provided through integrated models that include primary care (eg GP practices and consortia), social care, third or independent sector providers. Integration with primary care may help provide a particular focus on prevention and coordination of care, particularly for people with long-term conditions. PCTs may decide that some services are better provided at service line level through delivery that involves local authorities or other non-NHS bodies.

2.10 Greater integration can benefit individuals by providing a seamless care pathway across health and social care. Joint working and shared information mean that individuals have a single, reliable point of contact and combined visits from specialists. It will also mean that individuals have a more flexible service, with staff able to arrange care services and mainstream services.

2.11 Care Trusts were introduced in 2002 to allow NHS organisations and councils to deliver better-integrated health and social care. Where Care Trusts already provide community services, it is not our intention that this should cease, as we want to encourage innovation and greater service integration, but such arrangements must be reviewed to ensure they

meet the tests set out in Section 3, including the requirement for strong commissioning. Equally, where it is proposed that an existing Care Trust should take on the provision of community services, this should be considered, as long as the tests can be met and change fully implemented by 31 March 2011.

Social Enterprise

2.12 Social Enterprise 'Right to Request' schemes will continue to provide a further option for community services, building on the 'first wave' of 20 announced in November 2009. An assurance framework already exists for the right to request, which is administered through SHAs. Likewise, guidance already exists for Right to Request.

2.13 In developing the vision, values and mission for a social enterprise, it is important to involve staff, service users and other stakeholders. This should also involve the unions that represent staff and the Local Involvement Networks. Their buy in to this process and support will be key to success.[7] Proposals for Social Enterprises will therefore need to test the extent to which staff involved in the social enterprise are supportive of the proposals going forward.

Community Foundation Trust

2.14 Community Foundation Trusts (CFTs) are likely to be an option for a very few areas, as in many places other options will be more appropriate and can be implemented at pace. Appendix 1 to this document provides details of the national process for SHAs to nominate candidates for CFT status, and the approval and assessment of applications.

Continued direct provision

2.15 PCTs should principally be commissioning organisations. Circumstances may make it appropriate for some PCTs to continue the direct provision of services, but this will not be the norm. Proposals to do this will pass the tests when the provider is able to demonstrate the provision of exceptionally good services that are sustainable and support pathway change. Continued direct provision should not detract from the PCT's core role of commissioning, which should be of the highest standard. Direct provision will also be appropriate where it enables greater innovation in the delivery of integrated services, such as in a partnership arrangement with a local authority or local primary care organisation but again must also be matched by strong commissioning.

7 See Social Enterprise: Making a Difference, Department of Health, November 2008

3. The Assurance and Approvals Process

3.1 This section sets out an assurance and approvals process for decisions on organisational form for community services. The Department will run a separate national selection process for aspirant Community Foundation Trusts (CFTs) (for details see Appendix 1).

3.2 Proposals for all new organisational forms other than CFTs will be subject to a DH/SHA peer review process and SHA assurance and approval. This will include new Right to Request proposals**.** All proposals must meet the national tests set out in paragraph 3.9 below.

Role of Primary Care Trusts

3.3 The organisational form or forms that the PCT proposes to the SHA for approval in principle will need to meet the assurance tests set out below. In appraising options, PCTs should therefore take into account the national assurance and approvals process, including the assurance tests set out within this guidance.

Role of Strategic Health Authorities

3.4 SHAs will each manage their own process, by which they will:

> assure the PCT's proposed form or forms against the assurance tests

> approve the proposals in principle, following a joint review process with other SHAs and DH

> review retrospectively those proposals it has already approved but where transactions have not yet been agreed, to ensure that they meet the assurance tests

> review with NHS providers currently in the process of implementing a new organisational form that they are fit for purpose according to the assurance tests.

> ensure that the Regional Social Partnership Forum is fully engaged in the process of assurance, as set out in *Enabling new patterns.*[8]

Role of the Department of Health

3.5 The Department of Health will hold the SHA to account for its performance in carrying out the assurance and approval process, focusing in particular on the following three areas:

> Will the proposed form deliver the required substantial improvements in quality?

8 See paragraph 8.16

> Will it result in substantially increased efficiencies and generate sufficient savings to meet the quality and productivity challenge?

> Is the proposed form sustainable?

Criteria for proposals on organisational form

3.6 *Enabling new patterns of provision* provided best practice guidance on the decision-making process including involvement of stakeholders, users and staff. The guidance was clear that commissioners should lead the changes, setting out clear commissioning strategies based on assessment of needs and an understanding of services following service reviews.

3.7 This guidance builds on the guiding principles set out in *Enabling new patterns of provision*. Any proposal on provider form will be tested against the criteria below, set out in the NHS Operating Framework 2010/11. Proposals will need to demonstrate that they:

> are needs and pathway-driven

> provide more integrated and sustainable primary, community and secondary care services, which have the support of primary and social care

> deliver improved quality, including better patient experience as well as increased productivity

> are affordable, reducing management costs and transaction costs

> help to manage the demand for services more effectively (for example, reducing acute admissions and lengths of stay)

> demonstrate that potential providers have a track record of leadership capability, governance structures and culture to engage and empower staff to lead service transformation.

3.8 Proposals will also need to demonstrate effective and early staff and union engagement and good workforce practice, including the application of the Staff Passport. They will also need to demonstrate the extent to which staff wish to be involved in an organisation as stakeholders as well as employees.

Tests for proposals on organisational form

3.9 To assure PCT decisions against the criteria, SHAs will use a schedule of tests to ensure that the proposed organisational form will offer the greatest benefits across the whole range of tests, and PCTs will provide appropriate evidence against each. The tests are grouped in the table below within three critical areas: delivery of quality improvement; increased efficiency; and sustainability. They should be used in conjunction with the best practice guidance in *Enabling new patterns of provision*. Guidance on the Right to Request and a template for staff making requests to PCTs[9] should be referenced when a request is made to the PCT Board.

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090460

	No	Test	Areas to be assured by PCT and SHA
Quality Improvement	**1**	**Improving Outcomes** Will it meet patient needs and deliver improved local health outcomes as identified in the PCT strategic commissioning plan and Local Area Agreement (LAA), and significantly better patient experience (including Choice)?	• The fit with the PCT Commissioning Strategy and priority outcomes as identified in World Class Commissioning, including joint commissioning plans • That there are robust plans which show how patient experience for all groups will be significantly improved, and assess the impact on inequalities.
	2	**Improving Quality** Will it deliver significant improvements in quality of service and outcomes delivered?	• That there are identified improvements in quality of service outcomes to be delivered • That there is a clear plan and capability to shift from acute to out of hospital care • That the improvements in quality will be sustained
	3	**Service Integration** Will it deliver significant improvements in service integration and quality of health and social care?	• The proposals demonstrate at patient and pathway level how service integration will be enhanced to improve care • Show how the proposal supports primary, community, secondary, children's services and social care partners to increase prevention through more integrated approaches

	No	Test	Areas to be assured by PCT and SHA
Quality Improvement	**4**	**Stakeholder Engagement** Has it got the engagement and support of key stakeholder groups?	• The extent of engagement to date with all key stakeholders including staff, SPF, patients, the public, OSCs, LINKs and local service partners and their relevant partnership Boards • The extent of support from key stakeholders including staff, SPF, patients, the public, OSCs, LINKs and local service partners and their relevant partnership Boards • Specific plans for workforce engagement to deliver transformed services • Specific plans which demonstrate how the proposals will bind in the support of primary and social care and children's services • Evidence of robust planning involving all key stakeholders for: – future engagement and involvement – any necessary consultation
Increased Efficiency of Solution	**5**	**Efficiency Improvements** Will it deliver substantial improvements in the technical and allocative efficiency of the services being delivered?	• The proposals will help deliver the efficiency improvements set out in the NHS Operating Framework 2010/2011 • The proposals explain how, and the extent to which, they will deliver technical efficiencies in 2010/2011 and 2011/2012 • The proposals set out how allocative efficiencies will be delivered in 2011/2012 and thereafter • Identified reductions in fixed costs including management and transaction costs
	6	**Infrastructure Utilisation** Will it maximise utilisation of own (and any integration partners) estate and infrastructure?	• The proposals will identify steps to increase utilisation and efficiency of back office estate and other infrastructure. They will identify scope to share use of assets more efficiently with other partners including local authorities • How will the proposal improve the utilisation of all NHS owned or used estate and infrastructure? • The proposals will identify any surplus assets and infrastructure that will be released by the proposals

	No	Test	Areas to be assured by PCT and SHA
Sustainability of Solution	**7**	**Sustainability** Will it be clinically and financially sustainable?[10]	• Show how proposals will be sustainable in the long and short term, clinically, financially and in terms of infrastructure • Show how the proposals will give PCTs with LA and PBC partners the leverage in the local health economy to deliver – strategic commissioning plans – continued service transformation and realignment – continuing contestability and service innovation • Show how the proposals will ensure that the local health economy has and retains a sufficiently skilled workforce to lead, develop and deliver new service models
	8	**Whole System Fit** Will it fit into and enable delivery of wider health economy service transformation and shifts in care?	• Demonstrate how solutions will deliver whole health economy effectiveness and efficiency • Show how the proposals will fit into current and future patterns of acute and out of hospital provision • Show how the proposals will contribute to delivering significant wider health system improvements in allocative efficiency • Have any potential adverse impacts of the proposals elsewhere in the local or wider health economy been identified and are there proposals for the management of those impacts?

10 If any proposal for continued direct provision is being considered, then the host PCTs would have to demonstrate very strong commissioning skills, including performance in WCC assessments equal to the thresholds set in the NHS Operating Framework 2010/2011. If those performance levels were not sustained then the DH and SHAs would reserve the right to review any continued direct provision.

3.10 In addition, it is the SHA's role to ensure:

- the proposed form(s) is a legal entity
- it can be implemented by 31 March 2011, or as a minimum substantial progress can be achieved by that date towards final implementation of the new organisational form
- provider fitness for purpose, including: robust governance and leadership; sustainability; financial viability; workforce viability and engagement; involvement of patients, users and other stakeholders; and a willingness to implement Staff Passport and NHS Constitution provisions
- and that there is a clear and effective organisational development strategy.

3.11 It is also the SHA's role to ensure that Trade Unions are able to input information into these assessments.

Role of the Cooperation and Competition Panel (CCP) and Transactions Board following SHA's assurance process

3.12 SHAs are responsible for ensuring that proposals for transactions that are reviewable under the *Principles and Rules for Cooperation and Competition* benefit patients and taxpayers. Once an SHA has carried out an assurance process in order to ascertain that this is the case, the CCP will assess the consistency of the transaction with the merger provisions in the *Principles and Rules for Cooperation and Competition*. PCTs and other relevant parties are encouraged to make early contact with the CCP to discuss informally whether proposals are likely to raise concerns under the *Principles and Rules*. The Department is in discussion with the CCP and the Transactions Board to streamline approval processes and will provide further details.

4. Q&A

4.1 **Q. What happens if the preferred option does not pass the assurance tests?**

A. Where its preferred option does not pass the assurance tests, a PCT will be required by its SHA to review its proposal(s) and resubmit to the SHA, normally within two months. If the revised proposal(s) still do not pass the tests in this guidance, the PCT will be expected to consider a wider range of options. If not previously considered this should include the open competitive tendering of appropriate services.

4.2 **Q. What about Any Willing PCT Provider (AWPP)?**

A. Where PCT accredited Providers exist for community services this will continue to provide an option to introduce alternative patterns of provision locally.

4.3 **Q. How does the Social Enterprise Right to Request process fit into this assurance process?**

A. *Enabling new patterns of provision* makes it clear that staff should have the 'first call' to offer to provide services under new organisational arrangements and that existing staff and management should be given the opportunity to propose the creation of social enterprises through the Right to Request scheme.

Through the creation of social enterprises, staff will be enabled to set up and lead new organisations that can both empower staff and improve services to patients and users. This is intended to create the conditions where NHS staff can innovate and lead rather than being told what to do.[11]

This guidance does not change the Department's commitment in the *NHS 2010–15: from good to great* and the NHS Operating Framework 2010/11 to supporting Right to Request applications from PCT community staff, nor is it intended to alter the existing assurance process for them. We do, however, expect PCTs and SHAs to apply the tests set out in this guidance to such applications. We remain fully committed to supporting those PCT staff who wish to set up social enterprises. For existing Right to Request proposals, the approval of the 'Expression of Interest' stage is the same as the approval in principle requirements set out in this guidance.

4.4 **Q. Why will there be only a limited number of potential Community Foundation Trusts?**

A. The process for reaching CFT status is a long and demanding one. Given the pace of change needed to meet the quality and productivity challenge, we do not expect many providers other than the existing CFT pilots to be able to meet the requirements of the CFT process, in addition to passing the national tests set out in the guidance as part of the overall assurance process.

11 See Social Enterprise: Making a Difference, Department of Health, November 2008.

4.5 **Q. How does Secretary of State's statement that 'the NHS is our preferred provider' impact on consideration of options on future organisational forms for PCT-provided community services?**

A. This guidance is consistent with the vision set out by the Secretary of State in NHS 2010-2015 'from good to great': preventative, people-centred, productive.

Our commitment that 'the NHS is our preferred provider' was designed to give reassurance to staff in the context of an unprecedented amount of change and ensure fair processes are followed in the commissioning of services. Where it emerges during the discussions on future organisational forms that there could be a case for considering that services be put out to tender, the existing guidance underpinning 'the NHS is our preferred provider' must be followed.

4.6 **Q. Integrated care organisations are not mentioned as an option: how do integrated care pilots fit into this process?**

A. The guidance makes clear that services need to be increasingly integrated around the needs of individuals in order to deliver improved services and quality outcomes. In making decisions about the future organisational form for their community services, PCTs will need to take into account the local provider landscape, including the possible forms emerging through any integrated care pilots. They may wish to consider the integrated care pilot's possible form in their proposals as part of a range of options for the future shape of their community services.

4.7 **Q. Is the guidance suggesting that integration of community services with acute providers is the preferred direction of travel?**

A. The Guidance makes clear that there is no national blueprint for the future options which PCTs may select for their community services. The drivers for the changes are improved services, which are increasingly integrated to improve the quality and productivity of services, delivered in a sustainable way and which best meets the needs of individual users. The pattern of provision that most effectively delivers this outcome is best shaped locally in discussion with local partners.

4.8 **Q. Do PCTs need to engage with or consult on their proposals?**

A. Patients and the public should be involved in any proposed service change that may arise from an organisational change. Sustained engagement of patients, public, staff, their unions and representatives, and key stakeholders is essential. *Enabling new patterns of provision*, paragraph 4.1, makes it explicit that: "users of NHS services must be involved, not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered."

NHS bodies must comply with their duty under section 242(1B) of the NHS Act 2006, and have regard to the related guidance given under section 242(1G) of the Act. Legal

advice should be sought when it is unclear whether or not proposed changes trigger the organisation's obligation to comply with section 242 (the duty to involve). In addition, NHS Trusts are required to consult their staff under paragraphs 28 and 29 of Schedule 4 to the NHS Act 2006 and the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 1996. The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may also apply, depending on the proposal. Legal advice should be taken on staff consultation issues. We also expect SHAs to engage constructively with Regional Social Partnership Forums on workforce issues arising from this guidance.

4.9 **Q. How will salaried dental services be affected when implementation of a review of NHS dental services is already underway?**

A. These are complementary initiatives. The independent review of NHS dental services led by Professor Jimmy Steele suggested that local patient pathways and clinical networks could lead to a more appropriate use of these services. SHAs will be taking these points into account in considering PCTs' proposals for new organisational forms for their community services.

4.10 **Q. How will salaried medical services be affected by the guidance?**

A. Salaried GPs provide a range of important services, often to disadvantaged communities or individuals and groups who may otherwise find it difficult to access care, treatment and advice. It is essential that these services are sustained and not disrupted. To help ensure this, PCTs should consider options which achieve the best match for individual services with local commissioning priorities (based on health need and local people's views). PCTs should take into account that salaried medical services provided via a PCT provided PCTMS contract often contain a variety of service models which differ from traditional community services, and that therefore options should reflect what works best in local circumstances, rather than necessarily seeking a uniform approach.

Appendix 1: Selection of Community Foundation Trusts (CFT) candidates

A.1 The NHS Operating Framework 2010/11 indicated that 'strong proposals for CFT's will be considered when these meet our tests'. The DH expects this to apply to a very limited number of proposals, including, if successful, the original six CFT pilots. Following their selection, the CFT candidates will proceed to the NHS Transactions Board for approval to create an NHS Trust – a necessary precursor for consideration by Monitor to create an FT. In addition to meeting the tests as outlined above, proposals should be well developed in their planning for CFT status and should show evidence of both PCT Board and SHA agreement to become aspirant CFTs.

A.2 A small number of pilot CFTs have for some time been supported by the Department and host PCTs and SHAs, as they have evolved into mature CFT pilots.

A.3 In order for the CFT approvals process to proceed at pace in conformity with the overall assurance process for organisational forms, we have agreed with SHAs the following timetable:

By 12 February 2010

> SHAs will have submitted proposals for potential CFT candidates to the Department for consideration, along with appropriate evidence based on the tests for future PCT organisational form, as set out in Section 3 of this document.

and

> The Department, with SHAs, will have identified a 'shortlist' of the strongest applications, which will then be subject to review by the Department, supported by SHAs.

and

> The Department, supported by SHAs, will have assessed proposals against the tests and identified proposals which can go forward as candidate CFTs.

By 31 March 2010

> Candidate CFTs should have been considered by the NHS Transactions Board in order to secure a recommendation to the Secretary of State for Health to move them to NHS Trust status, a necessary precursor to the Monitor FT approvals process.

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