

**REPORT TO BOARD**

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**Contact Details:** Tel: 020 3049 4076  
**Date of meeting:** 20th November 2008  
**Subject:** **Organisational Development : Strengthening  
Commissioning And The Development Of  
Community Services`**

**For Decision**

**RECOMMENDATIONS**

The Board is asked to:

1. Note that specific proposals will be brought to January PCT Board to proposing organisational change and formal staff consultation to address these new arrangements
2. Note the PCT-wide approach taken to organisational development resulting from the work to address Strengthening Commissioning and the development of the PCT's community services.
3. Note the development of a London-wide "hub" - the London Clinical and Business Support Agency, to support PCT commissioning initiatives and that the PCT Board will be asked in December 2008 to approve a Business Case in support of this proposal.
4. Note new arrangements, including new governance arrangements for London-wide Specialist Commissioning to be hosted by Croydon PCT
5. Approve the development of and arrangements for a sector-wide vehicle to support PCT strategic commissioning initiatives on a sector wide basis
6. Approve the development of formal joint working through the establishment of an Alliance with Southwark and Lewisham PCTs as major commissioners of the proposed Academic Health Sciences Centre Trusts
7. Support the further development of the PCT's borough based commissioning arrangements

8. In relation to the PCT's community services:

(a) Note developments in the future provision of community services including the outcomes of the Fit for the Future discussion and engagement process;

(b) approve that Lambeth PCT Community Services should become an Autonomous Provider Organisation within the PCT from 1 April 2009, subject to formal consultation (if necessary) and all governance and due diligence being agreed at the March 2009 Board meeting.

(c) Agree the criteria and weights used to complete an initial option appraisal on 4 options that will inform and steer the debate on future organisational form

(d) Agree that future community services provision should operate according to the broad service models outlined in the Fit for the Future discussion paper.

(e) Agree that the PCT Management Team should work up proposed structures for community services to achieve these service models, for formal consultation

## **Introduction and Overview**

The PCT is about to enter the most exciting and probably the most testing phase of development we have seen since we were established in 2002. The prize is great: the transformation of services and health improvement right across the borough. And the driver is the Department of Health's national World Class Commissioning (WCC) programme.

Board members are already well aware of WCC. In combination with work across London to strengthen commissioning and our own project on provider independence, *Fit for the Future*, WCC will deliver radical improvement in two main strands:

- the transformation of our approach to commissioning for health improvement and quality, tackling inequalities, introducing real choice for local people, promoting flexible and personalised services and ensuring local people have much greater influence over how we spend taxpayers' money.
- the transformation of local provision of the full range of community health services, by their transfer to a thriving independent service organisation, separate from the PCT's commissioning arm and dedicated solely to providing excellent local services in Lambeth – and possibly beyond.

These massive aspirations are underpinned by some proposed organisational changes:

- consolidating the PCT's local commissioning responsibilities in a commissioning-only borough based PCT, with responsibility for driving the whole commissioning agenda, for health improvement, further strengthening our partnership arrangements with Lambeth Council, the commissioning of out-of-hospital services and for working with clinicians to develop Practice-based Commissioning.
- establishing an Alliance with Southwark and Lewisham PCTs for the commissioning and contracting of acute hospital services, making best use of the various scarce skills from the three PCTs' commissioning teams and creating economies of scale.
- establishing stronger strategic commissioning arrangements across all of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark for those acute hospital services that require a networked whole-sector approach and for the implementation of the service developments we expect from *Healthcare for London*
- establishing a London-wide "hub" – the London Commissioning and Business Support Agency – to provide some specialist support to all 31 PCTs.
- as indicated above, delivering independence for our service provider arm, separating it off from the commissioning arm. Initially, this will be by means of an "autonomous provider organisation" (APO) still – formally speaking – part of the PCT but operating as far as possible as if it were entirely separate. For the longer term, we need to look at the best organisational form for full and formal independence.

We propose to deliver these changes – including the move to APO – with effect from 1 April 2009. The timetable for moving beyond the initial stage of APO is yet to be decided.

The changes in organisational structure will facilitate the transformation we wish to see. But they will not of themselves deliver it. To do that we will need to secure step change in a number of areas of both commissioning and provision:

- radically boosting user and public engagement in everything we do, right through from strategic decision-making and priority-setting to face-to-face engagement in clinical settings.
- maximising the benefits of communications activities through exploring new opportunities to ensure a regular and systematic two way dialogue with our staff, partners and the local community.
- significantly increasing opportunities for clinician engagement in the leadership of commissioning as well as service provision.

- embedding quality in all we do and establishing comprehensive systems to ensure service quality information informs our commissioning decisions.
- developing and implementing provider market management as a means of improving service quality and offering users greater choice and more personalised services.
- knowledge management – and in particular the management of information and intelligence across and beyond organisational boundaries.
- supporting and developing our workforce to ensure we have the right number of staff with the required skills to successfully deliver this agenda.

The prospect of change always brings with it some uncertainty – for staff and Board members alike. So we will keep the Board and staff fully engaged and fully informed of developments, including messages to staff every Thursday on the intranet, throughout the whole process.

The MT has established a Strengthening Commissioning Programme Board which meets weekly to lead the change process. This group is also supported by an APO steering group.

I have spoken with the Chair about the need for work on overarching governance arrangements; and she and I will consider how best to take this forward. We shall keep Board members fully engaged with how we propose to manage this work; and how they can engage in it.

The rest of this paper sets out information on the various initiatives required to deliver the changes in organisational form to underpin the transformation we need to see. It seeks to inform Board members on progress in each; and seeks specific Board approvals.

**Kevin Barton**  
**Chief Executive**

# **Organisational Development: Strengthening Commissioning And The Development Of Community Services**

## **1.0 Initiatives**

The paper gives an overview of the following:

- Development of a London Wide hub
- London-wide Specialist Commissioning developments
- Development of a South east London sector PCT commissioning vehicle
- Development of a commissioning Alliance with Southwark and Lewisham PCTs
- Borough-based commissioning in Lambeth PCT
- Development of an APO and beyond in Lambeth PCT following the outcome of the Fit for the Future programme.

Progress and specific proposals on each of these projects is covered in supporting Appendices (A to F) and summarised below:

### **1.1 Development of a London Wide “hub”- the London Clinical and Business Support Agency (Appendix A)**

Under the London-wide Strengthening Commissioning initiative PCTs across the capital have been working together to establish a London-wide hub to provide common support and specialist functions across London PCTs. Multi disciplinary London – wide workshops have been held to determine the scope and ambition of the hub and a separate Business Case will be brought to all London PCT Boards for approval in December. Board members have already received briefing notes produced by London PCTs. It is likely that the hub will initially consist of existing services such as the Commissioning Support Service, the Healthcare for London Team and existing London-wide Public Health arrangements with proposals for further development around expert clinical and commissioning functions.

### **1.2 London-wide Specialist Commissioning**

In line with the recommendations of the Carter Report, a national review of specialised serves commissioning arrangements the London Commissioning Group has led the review of the existing specialist commissioning arrangements across London and specific proposals for strengthened specialist commissioning arrangements have been developed. A proposal to review the new London wide arrangements with new governance arrangements incorporating a single management structure, led by a Chief Operating Officer and hosted by a single PCT, Croydon, will be presented for approval by all London PCT Boards. Under the new arrangements Lambeth PCT would no longer be host for the London-wide Specialist Commissioning Group from 1<sup>st</sup> April 2009.

- 1.3 South east London sector PCT Commissioning vehicle (Appendix B)**  
Over the last three months, south east London sector PCTs have been developing our proposals in order to deliver improved strategic commissioning at a sector level, to enable the use of shared expertise and resources to better inform and undertake acute commissioning activities. Commissioning for key networks such as cancer and cardiac will be strengthened at sector level alongside aspects of Healthcare for London delivery, for example the networked provision of acute stroke and trauma services. A new programme office serving the six PCTs will also support the implementation of A Picture of Health and the development of PCTs' relationship with The Academic Health Sciences Centre. It will also support the set up of the sector commissioning vehicle. Arrangements will be governed by a new Joint Committee of PCTs, comprising the Chairs, Chief Executives and PEC Chairs of the six PCTs. The PCT Board is asked to support the approach and direction of travel being proposed with the final business case being presented to the January PCT Board.
- 1.4 Development of a commissioning Alliance with Southwark and Lewisham PCTs (Appendix C)**  
In conjunction with the sector vehicle there will be two commissioning alliances -one consisting of the 'A Picture for Health' commissioners of Bexley, Bromley and Greenwich and the other consisting of the Academic Health Sciences Centre (AHSC) commissioners in Lambeth and Southwark. Lewisham will play a part in both alliances initially, withdrawing to the AHSC Alliance as UHL consolidates its relationship with the AHSC. Lambeth and Southwark PCTs have been working closely for some time to develop further and formalise their joint working. A joint informal Board meeting with Southwark and Lewisham PCT Boards was held to discuss the development of the alliance and its initial scope and PCTs have since developed these proposals. The PCT Board is asked to support the approach and direction of travel being proposed with a view to final recommendations being presented to the January PCT Board prior to formal staff consultation to take effect from 1 April 2009.
- 1.5 Borough based commissioning in Lambeth PCT (Appendix D)**  
The PCT is drawing up proposals to further develop its borough specific commissioning arrangements. This will address aspects of partnership commissioning with LB Lambeth for specified client groups, primary care commissioning, including practice based commissioning, provider development and the commissioning of community services which, with the shift to out of hospital care is recognised as a priority area for development. The PCT Board is asked to support the approach and direction of travel being proposed with a view to final recommendations

being presented to the January PCT Board prior to formal staff consultation.

### **1.6 PCT Community Services (Appendix E (i) and (ii) )**

The PCT's Fit for the Future project commenced in 2007 and during September and October 2008 the PCT has held an extensive informal engagement exercise with staff, users and partners to discuss the findings of the project, the PCT's proposed vision for community services in Lambeth and to consider potential organisational forms. A Board seminar to consider the outcome of the exercise was held on 24th October 2008. It is proposed that the PCT moves to APO status for its community services from April 2009. This will require revised governance arrangements for the PCT. The PCT will also discuss likely future organisational forms using an initial option appraisal to inform and steer the deliberations. The PCT Board is asked to support the approach and the direction of travel being proposed with a view to further recommendations being presented to the January PCT Board prior to formal staff consultation.

### **2.0 Next Steps and Governance arrangements**

We are in the process of creating a comprehensive timeline to take account of consultation and engagement with staff, our Professional Executive Committee and partners. Recommendations will be made to the January 2009 PCT Board meeting for changes to take effect from 1 April 2009.

As part of this work our governance arrangements will need to be reviewed and updated and will be presented as part of the recommendations to the January 2009 Board meeting.

### **3.0 Conclusion**

The Board is asked to support the PCT's direction of travel in relation to strengthening its capacity and organisational arrangements, often working with PCT partners, in support of the PCT's World Class Commissioning development. Specific approvals related to proposed new Specialist Commissioning arrangements are sought.

The Board is asked to note the outcome of the Fit for the Future Project including the views of service users, partners and staff. The Board is asked to approve the proposal to establish an APO from 1<sup>st</sup> April 2009. The Board is also asked to support the approach to determining the longer term organisational form.

The Board is asked to note that specific organisational change recommendations will be brought to the January Board proposing formal staff consultation

Resource Implications	The PCT has set aside resources within the 2008/09 Operating Plan and CSP (refresh) to address Organisational Development. This will need to reviewed in the light of final organisational development proposals.
Public and User Involvement	Fit for the Future was informed by a Reference Group which included voluntary sector input. Market research included focus groups with service users.
Staff Involvement	PCT staff have been involved in drawing up proposals and over 180 people have attended staff events during recent Fit For Future engagement exercise.
Equality and Diversity Implications	Fit for the Future work has incorporated equality and equity screening and this is ongoing.
Related Standard for Better Health:	C7 Governance

**Development of a London Clinical & Business Support Agency (LCBSA)**

London PCTs are working together on a significant programme of work to strengthen commissioning capability and capacity by April 2009. A key element of the strengthening commissioning programme is the proposal to develop a London Clinical & Business Support Agency (known as the 'hub') and it is currently planned to bring an LCBSA Business case to all London PCT Boards in December 2008. Chas Hollwey (CE, Barnet PCT) is leading the development of the LCBSA proposal. The proposal will seek to:

- Provide new capabilities needed to support achievement of World Class Commissioning
- Avoid duplication of effort and waste
- Pragmatically focus on commissioners' most pressing needs
- Ensure strong accountability to commissioner clients
- Generate synergy value from existing shared support resources
- Free up commissioners' time

A number of workshops have been held to scope out the potential priorities for the LCBSA. It is likely that it will offer a range of both core services and additional optional products. Services currently being considered for inclusion in the "hub" include:

- Healthcare for London: Care pathway design and capacity planning for pan-London prioritised programmes
- Clinical advice: clinical expertise and a quality observatory
- Public health: health intelligence, public health development programmes and social marketing
- Commercial services: provider intelligence, performance measurement and commercial support and market intelligence
- Communications support
- PCT development
- Operations and Informatics (data warehousing etc)

The LCBSA is expected to be hosted by a single PCT. It will have a governance structure that is represented by each of the sectors across London and an annual Committee with representatives from all 31 PCTs to oversee this.

**Next steps:**

- Further focus groups to take place covering organisation, clinical, public health, and commercial aspects
- A draft business case will be presented to Chief Executives on the 20th November
- The business case will be submitted to NHS London for sign-off during w/c 24th November

- The Final Business Case and Implementation Plan will be distributed to PCTs on 1st December for dissemination to PCT Boards
- PCT Boards will meet between 8th and 19th December to consider the Final Business Case and Implementation Plan

### **South east London sector PCT Commissioning vehicle**

The PCTs in south east London have been developing over the last three months proposals around strengthened strategic commissioning at a sector level, alongside other London Sectors.

There is now agreement around the scope of a sector wide strategic commissioning programme as follows:

- Two alliances within south east London to take forward the acute contracting and commissioning function:
  - A Picture of Health Alliance
  - Lambeth, Southwark and Lewisham alliance
- Service redesign for tertiary services
  - Networks for cancer, cardiac, renal and end of life care.
  - Healthcare for London – stroke and trauma
- Strategic relationship with Academic Health Sciences Centre
- Technical support to the sector.

In addition proposals are in place related to proposed future governance arrangements for sector commissioning as follows:

- All PCT Boards to feed in to a Joint Committee of PCTs.
- Overall executive delivery and governance of sector commissioning overseen by SEL Collaborative Commissioning Group
- Sector Commissioning vehicle, two alliances, workstreams for service redesign of tertiary services and technical support functions.
- All elements of the sector commissioning programme to have Senior Responsible Officers at Chief Executive level.

The next steps are to develop a sector commissioning vehicle business case by the end of January 2009. A Programme Office to take forward all elements of the proposals to a standardised approach is being put in place and interim effective programme governance arrangements have also been agreed.

The work to develop the business Case will include consideration of corporate resource support to sector commissioning and the interface between London-wide hub, sector vehicle, alliance and borough based commissioning proposals.

Simon Robbins, CE of Bromley PCT is the SRO for the overall Sector programme.

**Development of a commissioning Alliance with Southwark and Lewisham PCTs**

Lambeth and Southwark PCT Boards, plus representatives from Lewisham PCT, met on 2 October 2008 to discuss the options for developing further and more formally collaborative commissioning arrangements across the PCTs.

These discussions took place within the context of the wider south-east London work on Strengthening Commissioning, as one of the two proposed commissioner Alliances (A Picture for Health and Academic Health Science Centre/LSL) encompassing part of the planned sector strategic commissioning vehicle.

The joint Board meeting considered options that the Lambeth and Southwark PCT Management Teams had developed related to both form and function for collaborative commissioning and authorised the development of more detailed business case proposals for future consideration. The paper considered on 2 October, which looks at those areas that should optimally be delivered jointly and those which should remain at borough level, is attached at Annex A.

Board members will recollect that at the meeting there was broad consensus in relation to function – with the planned minimum scope of the alliance to include acute contracting, commissioning and primary/secondary care interface care pathway design.

The differing options around form (lead/hosted arrangements, stand-alone team with dual accountability, contracted out) were considered with a preference for arrangements that enabled true dual accountability, but a recognition that the business case needed to consider these options and potential advantages and disadvantages of each in more detail, to ensure proposals are effective and optimal in relation to governance issues.

The PCTs have subsequently employed Martin Roberts, an external consultant to work with the PCTs in developing the business case proposals. Martin has met with a number of representatives across the PCTs and will be submitting a first draft business case paper for consideration in mid November 2008. The proposals will consider in more detail the options around function and for the LSL Alliance.

In taking forward the proposals around the LSL Alliance we will also need to consider linkages across and fit to other elements of the Strengthening Commissioning work, specifically proposals for the London hub, the SEL Strategic Commissioning Vehicle and Lambeth PCT's plans around the

development of borough based commissioning. We will also need to consider how the Alliance accesses corporate support functions and how it secures clinical engagement and leadership.

Further discussion will take place following receipt of the first draft business case paper over November and December. The intention is to submit to the January 2009 Board definitive proposals prior to formal staff consultation, with the aim of implementing agreed changes for 1 April 2009.

**Borough based commissioning in Lambeth PCT**

The PCT has initiated work to consider issues of function and form in relation to PCT borough based commissioning, as part of Strengthening Commissioning.

The functions of borough based commissioning are relatively clear, as follows:

- Health improvement
- Commissioning and development of primary care services.
- Commissioning of community services.
- Joint commissioning with the local authority for key NHS/local authority interface client groups and care pathways: mental health, learning disabilities, older people, physical disabilities, children and young people, staying healthy.
- Development of Practice Based Commissioning – recognising the need also for good PBC links to the LSL Alliance.

Further consideration is required on optimal delivery of corporate commissioning functions, such as Commissioning Strategy Plan, Operating Plan and performance management. Whilst borough based PCTs will lead and co-ordinate these functions key contributions will be required from both the LSL Alliance and the south east London strategic commissioning vehicle, in terms of inputs and subsequent implementation and delivery. We need therefore to get relationships and linkages right to ensure successful delivery of these more strategic and overarching functions.

Further consideration is also required in relation to the optimal delivery of corporate support to the commissioning function – areas such as information, finance, public health, communications and engagement. These functions will be required at both borough and Alliance level to make a reality of our commitment to multi disciplinary commissioning.

The PCT has employed Kirstie Galbraith, an external consultant to carry out the work to produce a business case for borough based commissioning, working to the same end point time scales as the work on the LSL Alliance. Kirstie will be meeting with key members of staff over the next couple of weeks and working closely with Martin Roberts. She will be producing first draft proposals by the end of November 2008. We will then need to think through and develop detailed proposals in terms of organisational structure and posts to support the proposed function. The intention is to submit to the January 2009 Board definitive proposals prior to formal staff consultation, with the aim of implementing changes for 1 April 2009.

The paper considered at the joint Board meeting which looks at those areas that should optimally be delivered jointly and those which should remain at borough level is attached at Annex A.

**Lambeth and Southwark Board Discussion Paper**

**Transforming Inner South East London NHS – Lambeth and Southwark Commissioning – Working Better Together**

**For circulation to:  
Lambeth and Southwark SMT and NEDS  
Lewisham Chair, CE and DoC.**

**Background to Lambeth and Southwark collaborative commissioning arrangements**

Lambeth and Southwark PCT are both six years old, have very similar population demographics and have a history of joint networks spanning GPs, provider services, clinical redesign work, modernisation initiatives, joint approaches to acute commissioning (including mental health) and strategic planning.

In January 2008, the chief executives of both organisations indicated that they wished to explore a more formal way of cementing our commissioning arrangements. Over the last year Lambeth and Southwark PCTs have worked closely with the other PCT in the south east sector on the A Picture of Health project. This project has also been consulted on and the other SE London PCTs are taking forward the necessary redesign work. Lambeth and Southwark PCTs are not as closely involved in this programme of work now as the implications are greater for the outer London PCTs than inner London. However Lambeth and Southwark continue to work closely together on a number of care pathways and commissioning intentions. These include joint working on planned care, unplanned care, mental health and long term conditions (diabetes, stroke and vascular disease). We have agreed and prioritised care pathway redesign focussing on diabetes, CVD/stroke, maternity, mental health, MSK and ophthalmology.

In addition to this joint approach to service redesign we had already started to formalise our joint working on commissioning (this predates the Strengthening Commissioning programme of work). This includes a joint approach to acute commissioning at both KCH and GSTT, planned care through the above mentioned pathways and mental health commissioning.

The priority for Lambeth and Southwark PCTs over the next year is to continue to strengthening our commissioning capacity, embed care pathway redesign work (this includes the integration of health and social care services), support the provider services move to an Autonomous Arms Length Organisations, and lead a significant consultation and engagement exercise with the local population, staff, stakeholders and other partners that aims to describe the NHS in Inner South East London and the vision for the future.

### **Background to the 'Strengthening Commissioning' programme**

During this time NHS London declared all London PCTs are required to consider what actions they need to take to 'strengthen' their commissioning abilities. This is particularly relevant to acute commissioning but consideration must also be given to the commissioning of mental health, client group and provider services. It is expected that sector wide solutions will be found including pooling skills and capabilities, information, staff and potentially finance.

In June and July 2008 Lambeth and Southwark PCTs commissioning, public health and finance staff held a number of meetings to explore the scope for greater collaboration across the two PCTs in relation to commissioning, focussing primarily on acute commissioning but also looking at other areas of commissioning included within the scope of the proposed borough based commissioning arrangements.

Detailed discussions are continuing across south east London to develop fully worked up proposals for Sector commissioning, Borough based commissioning, and Provider services for submission to NHS London in October 2008.

The draft London wide commissioning intentions and business rules of London PCTs for acute services 2009-2010 include a deadline of 28<sup>th</sup> February for the sign off of all contracts. Working backwards this means that agreements / arrangements for host PCTs etc will need to be agreed well in advance of February.

### **The Strengthening Commissioning proposal**

The SEL PCTs have agreed that working collaboratively across all six boroughs is the most effective way of strengthening commissioning across SEL.

Agreement has been reached that the overarching strategic planning related to Healthcare for London (and associated local developments of APOH/AHSC), strategic planning for cancer, cardiac and renal services and oversight of specialised services is most appropriately carried out at Sector level, along with a hub providing for all organisations scarce skills and expertise. However the detail of what else is to be included and what this means in practice is still to be agreed – i.e. what is most effectively commissioned at the sector level rather than at a borough level.

There are two options currently under discussion in the SEL sector. One focuses on including all acute commissioning within the sector cluster, the other proposes establishing two 'commissioning' clusters reflecting patient flows to the acute's and the secondary / primary care pathways commissioned from the acute's, providers and local authorities. This would mean that acute commissioning for Lewisham, Bexley, Bromley, and Greenwich would be covered by one cluster within the sector arrangements and the acute commissioning for Lambeth and Southwark would be covered by a second joint Lambeth and Southwark cluster

within the sector arrangements. Attached as appendix one is a list of the potential options, advantages and disadvantages.

The principle behind the proposal of two clusters is a reflection of the patient flows and care pathways.

The Lambeth and Southwark cluster assumes that the acute commissioning function, including contracting, is carried out for Lambeth and Southwark at borough level through a collaborative or joint team arrangement.

Some consideration will need to be given to the best form of collaborative commissioning with Lewisham in recognition of the patient flows to KCH and GSTT from Lewisham.

### **Preferred option**

The preferred option is that Lambeth and Southwark PCTs continue to build on the six years of collaborative working and develop further the joint commissioning team arrangements at borough level.

The recent collaborative work across the sector should also continue. This includes taking forward the networks developed through the A Picture of Health programme of work and would include collaborating at sector level on overarching strategic planning related to Healthcare for London, sector wide planning for cancer, cardiac and renal services and specialised services.

### **Recommendations**

The Lambeth and Southwark Directors of Commissioning are tasked to work up the detail of the proposed joint / collaborative arrangements and a project plan. (Timescale to be determined)

**Table 1: Scope for collaborative commissioning**

<b>Areas of collaboration</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Recommendation</b>
<b>Do Nothing option</b>	No change for commissioning staff or to consider the options below.	<ul style="list-style-type: none"> <li>• Unable to strengthen commissioning</li> <li>• Failure to utilise current commissioning capacity in an efficient way</li> <li>• Doesn't show response to WCC/NHSL requirements</li> </ul>	Not a viable option to convince NHSL we are strengthening commissioning. Does not address need for more formal collaboration across L/s already identified as optimal by the two PCTs.
<b>Acute contracting</b> <i>Contract negotiation, contract monitoring and performance management.</i>	<ul style="list-style-type: none"> <li>• Easily definable and discrete element of the commissioning function.</li> <li>• Economies of scale, reducing duplication across the two PCTs.</li> <li>• Consistent approach across the providers for whom LPCT/SPCT act as co-ordinating commissioners – GST/KCH.</li> <li>• Minimal disruption to PCTs.</li> </ul>	<ul style="list-style-type: none"> <li>• Separation of contracting from rest of commissioning mitigates against effective care pathway commissioning, co-ordination across the commissioning cycle and relationships (providers and PBCs).</li> <li>• Posts unattractive as focus solely on contracting rather than wider commissioning.</li> </ul>	To be included in the joint arrangements, but will need more than this to make a viable team.
<b>Acute commissioning</b> <i>Service planning, review and implementation for acute service issue e.g. maternity services.</i>	<ul style="list-style-type: none"> <li>• Relatively easy to define.</li> <li>• Economies of scale, reducing duplication across the two PCTs and increasing capacity for managing and delivering the wider acute commissioning agenda.</li> <li>• Consistent approach across the providers for whom LPCT/SPCT act as co-ordinating commissioners – and consistent provision of patients.</li> </ul>	<ul style="list-style-type: none"> <li>• Separates out acute service issues/reviews from wider care pathways.</li> <li>• Depending on governance arrangements, could reduce ownership of service issues by wider stakeholders eg PBC/Local authority</li> </ul>	To be included in the joint arrangements

**Care pathway commissioning – primary/secondary interface.**

*Co-ordinating and leading the strategic planning, development and delivery of commissioning intentions for key interface care pathways : long term conditions, sexual health, unscheduled/urgent care, planned care, end of life care.*

- Easier recruitment and retention with combined commissioning/contracting roles.
- Provides coherence and whole care pathway planning across the full range of care pathways focussed around the primary/secondary care interface.
- Clearly links care pathway planning with acute commissioning/contracting within a continuous commissioning cycle for acute services.
- Team more attractive to recruit to as posts will offer a combination of care pathway and contracting experience.

Separation from commissioning/contracting for primary care and community services – potential fragmentation of the care pathway

To include the key care pathways related to the primary/secondary care interface - LTC, sexual health, maternity, urgent care, planned care, end of life care.

**Primary care and community services commissioning**

*Contracting for primary care independent contractors and community services. Implementation of care pathway/client group commissioning intentions.*

Provides within one team/focus whole of commissioning (from needs assessment to contract implementation) related to primary/secondary care interface care pathways. Team more attractive to recruit to as provides a combination of secondary and primary care experience.

Separates out primary /secondary care from client group commissioning – mitigates against effective links across these services and client group commissioning e.g. mental health in primary care. Depletes the scope of each PCT's individual borough based commissioning function.

In the first instance, it is considered that commissioning of primary care and community services should not be included in the joint team, but that informal collaboration should be pursued, with the potential to increase the scope of the formally constituted joint team at a later date.

NB Commissioning includes the functions of contracting, commissioning along care pathways, relationship management and provider development

**Mental health – commissioning from SLAM**

*Contract negotiation, contract monitoring and performance management, Service planning, review and implementation for acute service/SLAM specific issues.*

Co-ordinates secondary care commissioning in one place, and ensures equivalent approaches across secondary care providers. Reflects Academic Health Sciences Centre provider configuration, Ensures a joint approach across Lambeth and Southwark to SLAM.

Separates SLAM from rest of mental health commissioning – mitigates against whole care pathway approach for mental health. Potentially disadvantages local authority input to SLAM commissioning.

There is clear merit in collaborating on SLAM, particularly under the AHSC umbrella – however further clarity is required in relation to the links between the SLAM contract and the Section 31s in place in each Borough, to determine the extent to which this collaboration should be formal or informal.

**Practice Based Commissioning – Managing the relationship with PBC consortia, developing PBC.**

- Links PBC colleagues with PCT commissioners of secondary care services.
- Enables joined up approaches to secondary care commissioning.
- Facilitates PBC involvement and engagement in secondary care commissioning.
- Economies of scale – linking acute planning processes with PBC budget setting.
- Facilitates common approaches across PBC consortia working with the same providers.

- Depending on scope of the team separates out PBC from primary/community commissioning (& PCT expertise in these areas);
- Potential risk of PBC having a less focus on the local population/community

There are different approaches to PBC relationships across the two PCTs. . As a general principle it was considered that PBC relationships should sit within PCT commissioning and that there was a clear need to discuss further the links of PBC with the Borough based team as much of PBC commissioning would relate to the cluster commissioning team.

**Care pathway commissioning – client groups**

*Strategic planning, development and delivery of commissioning intentions for key client groups, that are most appropriately commissioned on a joint basis with the Local Authority – mental health, learning disabilities, physical disabilities, older people, children and young people.*

It has been assumed that these areas of services, which are currently jointly commissioned across PCT and local authority partners, will continue to be so, under borough commissioning.

**Table 2: Organisation and governance - options**

<b>Options</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Staffing</b>
<p><b>A virtual team.</b> PCTs continue to have separate, dedicated commissioning teams across their entire commissioning portfolio, but with agreed joint working arrangements in place across the two PCTs for areas where it is agreed to work together.</p>	<p>Easy to implement, with minimal disruption. Retains significant commissioning function/staff within borough based teams. Facilitates whole system/care pathway focus at borough level. Retains existing commissioning expertise, knowledge and history.</p>	<p>Fewer economies of scale, as functions will be replicated across each PCT. No real change to current practice, unless formalised – which makes a demonstration of strengthened commissioning a challenge. Dilution across the two PCTs of commissioning skills and capability, particularly scarce skills.</p>	<p>No significant change – but staff commitment from both PCTs for joint pieces of work may need to be formalised to secure maximum impact.</p>
<p><b>A lead PCT arrangement.</b> One PCT leads the commissioning of an agreed portfolio of commissioning functions/services on behalf of both PCTs.</p>	<p>Relatively easy to implement and structure PCTs are already familiar with. Provides some economies of scale, reduced duplication across the two PCTs and potentially improves access for both PCTs to scarce skills. Retains significant commissioning function/staff within borough based teams. Retains existing commissioning expertise, knowledge and history.</p>	<p>Mitigates against whole care pathway planning/focus for the non lead PCT. Potentially reduced influence/involvement of non lead PCT. Focus of team potentially skewed to lead PCT rather than both PCTs equally.</p>	<p>Would require a restructuring in both the lead and non lead PCT, plus transfer of staff to lead PCT. Could have a hybrid shared lead arrangement whereby the lead role for different projects/providers is shared on the basis of different projects?</p>
<p><b>A stand alone team.</b> A separate, stand alone team is created, reporting jointly to each PCT. (Need to determine scope – i.e. whether assume for acute commissioning/care pathway commissioning only, rather than PBC and borough commissioning?)</p>	<p>Clear dual and equal accountability to both PCTs. Ability to provide a dedicated focus on the agreed functions/scope of the team. Provides economies of scale, reduced duplication across the two PCTs and potentially improves access for both PCTs to scarce skills Retains existing commissioning expertise, knowledge and history within the PCTs.</p>	<p>Work required to ensure appropriate governance and accountability back to the PCTs. Loss of expertise from mainstream PCT Borough commissioning function. Splits commissioning across the care pathway in to distinct teams.</p>	<p>Team would need to be hosted for employment purposes by one of the PCTs. Would require restructuring and division of functions/staff between mainstream PCT commissioning and stand alone team. Would it require a SRO to be responsible for it?</p>
<p><b>Outsourcing.</b> The</p>	<p>Ability to choose a</p>	<p>Splits commissioning</p>	<p>Would need PCT</p>

<p>PCTs sub contract with an external provider to deliver an agreed portfolio of services on behalf of both PCTs.</p>	<p>provider able to demonstrate best fit for purpose in delivering agreed portfolio of services. Does not dilute PCT commissioning capacity and capability. Governance/accountability clear through SLA arrangement.</p>	<p>across the care pathway in to distinct teams, one of which is not PCT owned. Loss of existing commissioning expertise, knowledge and history in delivering agreed portfolio of services. Potential need for reduction in PCT staffing.</p>	<p>restructuring as functions are transferred to an outsourced provider.</p>
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Note – Should review lessons learnt from previous joint work to reorganise functions e.g. SSDP, Health First, Health Protection

## PCT Community Services

### **DEVELOPMENT OF LAMBETH PCT COMMUNITY SERVICES INTO AN AUTONOMOUS PROVIDER ORGANISATION**

#### **1. Summary**

In order to achieve our vision for the future of community services provision in Lambeth, the PCT's community services need to operate in a more autonomous way with a high degree of independence from the commissioning function of the PCT. We are therefore proposing that the community services of the PCT become an Autonomous Provider Organisation (APO) from 1 April 2009. This would be an organisation within the PCT but with a delegated governance structure and acting with a high degree of autonomy.

Appendix F (ii) covers the issue of determining a final organisational form for the PCT community services. It is desirable, with a view to minimising the amount of change for staff and users of community services, that the structure of the APO should be as close as possible to the proposed final organisational form that will follow, as far as can be determined or anticipated at this time.

#### **2. Background and context**

There is a range of national and London policies that support the development of community services into stronger, more independent business like organisations focussed on improving out of hospital services. PCT Chief Executives across London have considered these national and more local developments and have agreed that in London, PCT community services should move to Autonomous Provider Organisation status by 1 April 2009. The key policies that support the recommendation that the directly managed services should become an APO on 1<sup>st</sup> April 2009 are:

The 2006 White Paper, *Our Health, Our Care, Our Say* which set out:

- That the principal activity of PCTs is to commission health and social care for their resident populations.
- That PCTs need to formally separate their commissioning activities from their community provider services (for the reasons above) and consider how, in the light of this separation, innovation and best value in provision can be achieved.

Other factors influencing the move towards separation are:

- the vision expressed in Lord Darzi's NHS Next Stage Review to develop strong vibrant community services.
- government policy to extend competition and patient choice across the NHS, including a requirement on PCTs to review their community provision in 2008/9
- moving services closer to where people live
- strengthening clinical leadership in line with the recent "High Quality Care for All" report from the Department of Health

- a movement to join up services with the local authority, particularly for children's services, in order to improve the way that services work together to support individuals and families with complex needs
- work across London PCTs to develop arms length and more autonomous community provision as a stepping stone to more independent community providers
- the World Class Commissioning assessment which reinforces the commissioning role of PCTs.

During the summer and early autumn, the PCT set out its proposed vision and held a wide ranging discussion of its Fit for Future programme. This discussion trailed the proposal to develop an APO in Lambeth, considered what organisational arrangements might be appropriate and considered longer term solutions. The feedback from staff, partners and users was broadly positive to the development of greater autonomy and independence for the directly managed community services.

### **3. Vision for the future of Lambeth Community Services**

Having listened carefully to the feedback from our staff, our users and our partners in the Fit for the Future discussion, the provider services has a powerful vision for the future of community services in Lambeth.

We wish to create a strong and successful provider of NHS community health services in Lambeth that has the freedom to operate in a more business like way and where the senior clinical and managerial leadership teams are fully focussed on service improvement, innovation and provision of high quality services where improving access and delivering services along care pathways are a priority. We want to create an organisation that is focussed on meeting the health needs of the diverse local Lambeth community, that is rooted in Lambeth and that has the Lambeth community as its first priority for the delivery of core community services. We see the organisation as being an employer of choice, particularly within the local community in Lambeth. We need an organisation that is vibrant and confident in its own right and that has a strong and close working relationship with its allies, in particular local GPs, our partners in the local authority and others with whom we work to deliver services along the care pathway. Crucial to this will be to further develop and strengthen our localities as our partner organisations increasingly align themselves with these. We also see the organisation as being outward looking and one that is able to take opportunities to further develop the provision of specialist services to communities beyond Lambeth where appropriate, provided this does not adversely affect the quality of provision in Lambeth.

### **4. Programme plan to achieve APO status**

Our Transformation Work Plan to achieve APO status is a combined programme with the move to a final organisational form. A copy of the Transformation Work Plan is at Annex B.

The plan is organised according to the 6 domains and 39 criteria used by NHS London in their diagnostic tool for assessing readiness to become an

APO. In order to be approved for APO status we need to achieve the maximum score of 8 for 23 mandatory criteria and to be able to demonstrate adequate progress for the remaining criteria. In our latest self-assessment undertaken on 31 October 2008 the mandatory criteria where there is further work to be done included:

- To reduce dependence on income from host PCT
- Identifying opportunities for further cost efficiencies
- Agreement of SLAs for back office support functions
- Separation of the balance sheet (which will include asset management)
- Top team skills assessment
- Regular measurement of patient satisfaction

As part of the approval process, we have a peer review session on 25<sup>th</sup> November with City and Hackney PCT, supported by Partnership UK (PUK). City and Hackney PCT are one of the NHS London first wave APO PCTs and they will help us assess our readiness to become an APO. A challenge session with NHS London will take place in January 2009 to determine the final approval.

We are also aware that through the work of the NHS Transforming Community Services Programme Board new guidance will be issued in December along with the Operating Framework and our programme plan will need to be reviewed in line with this guidance.

## 5. Recommendation

The Board is asked to:

- a) note the developments in the future provision of community services including the outcomes of the Fit for the Future discussions and engagement process;
- b) approve that Lambeth PCT Community Services should become an Autonomous Provider Organisation within the PCT from 1 April 2009, subject to formal consultation (if necessary) and all governance and due diligence being agreed at the March 2009 Board meeting

## Annex B

### FIT FOR THE FUTURE: DETAILED TRANSFORMATION WORK PLAN

**This plan covers both work towards APO status and the final organisational form for Lambeth PCT community services**

Key to initials:

- AD – Angela Dawe, Director PCCS
- ADs – Assistant Directors
- AE – Andrew Eyres, Director of Finance
- AW – Amanda Williams, AD Nursing
- CC – Christine Caton, AD Finance
- DB – Dan Barnes, Senior Information Analyst
- ES – Ed Seward, AD Finance
- GB – Gill Black, Director of Nursing
- GT – Gail Tarburn, AD Workforce
- HB – Heather Blake, AD LTC & North Locality
- HBD – Head of Business Development (to be appointed)
- KG – Kenny Gibson, Information Manager
- Prov Dev Cttee – Provider Development Committee
- PG – Philipsia Greenway, Transformation Programme Manager
- SI – Sandra Iyawa, Transformation Programme Accountant
- SIs – Safina Islam, Equality Impact Assessment Adviser
- TIA – Transformation Programme Information Analyst (to be appointed)
- UD – Una Dalton, Director of HR & Corporate Affairs

		Action no	Actions	Timing	By whom
<b>1</b>	<b>Strategy</b>				
1.1	Vision for the future	1.1.1	Outline vision included in discussion document with wide engagement of staff & partners  Development of 3 year business plan and transformation plan for community services:	Aug 08	Done-will be reviewed in Oct based on feedback
		1.1.2	Prepare financial model of proposed service models and shortlisted organisational forms	Nov – detailed work plan being done	ES/CC/SI
		1.1.3	Assess income & cost of proposals in discussion document, including variants		
		1.1.4	Undertake financial risk analysis (eg decommissioning key services)		
		1.1.5	Cross-reference to service redesign work underway (see 2.4) – will not be complete	Nov	PG/SI
		1.1.6	Identify required changes in organisational & governance capacity, workforce skills, premises & IT	Nov	PG/GT
		1.1.7	Identify training & development requirements	Nov	PG/GT
		1.1.8	Start to draft business & transformation plan	Nov	PG
		1.1.9	<i>Decision on final service model and organisational form: see actions under 5.2</i>	Jan	PG
			Amend draft business & transformation plan following Board		

		<b>Action no</b>	<b>Actions</b>	<b>Timing</b>	<b>By whom</b>
		1.1.10	decision and feedback from APO peer review and challenge session  Business & transformation plan signed off	Feb	Prov Dev Cttee
1.2	Review of service lines	1.2.1	1 <sup>st</sup> stage of review completed and used to inform discussion document	July 08	Done
		1.2.2	Revisit review of service lines once service redesign work complete	Mar 09	PG
1.3	Relationships with commissioners	1.3.1	Bilateral with Lambeth PCT commissioners	Nov 08	AD/ADs
		1.3.2	Organise bilaterals with neighbouring PCT commissioners	Nov 08	PG
1.4	Commissioning intentions of PCT/PBC	1.4.1	Maintain involvement of Lambeth PCT commissioners in Fit for the Future process and design of new services – review after CSP refresh and Op Plan	Sept 08 – Apr 09	AD/HB
		1.4.2	Link with neighbouring commissioners, particularly Southwark, over future commissioning intentions	Sept-Mar	AD
		1.4.3	Organise discussions with PBC consortia, establish commissioning intentions and fit with our planned service directions	Oct	PG/HB
		1.4.4	Further develop relationships with LA commissioners – CYPS and Adult Services	Sept-Mar	PG/AD

		Action no	Actions	Timing	By whom
1.5	Competitive analysis	1.5.1	Initial benchmarking of services against other PCT data	June 08	Done
		1.5.2	Find "partner" PCTs or benchmarking club to benchmark more specialist services	Sept 08	Done
		1.5.3	Analysis against local competitors	Oct 08	PG
1.6	Competitive environment of APO	1.6.3	Initial proposals on service portfolio for discussion	Aug 08	Done
		1.6.4	Refinement including discussion with other local providers	Sept-Oct	PG/HB/ AD
1.7	Impact of wider healthcare changes	1.7.1	Environmental analysis undertaken (demographic changes, policy background and impact/opportunities of technology)	May 08	Done
		1.7.2	Look at impact of Darzi, Strengthening Commissioning and APOH	Oct 08	AD/HB
1.8	Partner relationship management	1.8.1	Partners (GPs, acute and mental health Trusts, local authority, voluntary sector) engaged in developing vision for discussion document	Spring 08	Done
		1.8.2	Bilaterals with partners, GP conference and voluntary sector workshop during discussion period	Sept-Oct	Done

		Action no	Actions	Timing	By whom
		1.8.3	Market research with service users	Oct	Done
		1.8.4	Engagement of partners during formal consultation	Dec-Feb	PG
<b>2</b>	<i>Operations</i>				
2.1	Data control	2.1.1	Clear list of service lines with staff and other inputs to each line including overheads	Aug 08	Done
		2.1.2	Documentation clear and available on Lamshare: Service analysis, decision processes, responses to discussion document, notes of bilaterals etc	Ongoing	PG
2.2	Activity reporting	2.2.1	Activity reporting feeds into balanced scorecard and used to inform service planning	Sept 08	PG/SI/DB Done??
		2.2.2	Ensure coverage and use of RiO is robust enough to provide reliable activity reports for every service line	By Mar 09	KG/ Service mgrs
2.3	Information management systems	2.3.1	RiO version 4.7 or EMIS in place across all services	June 08	Done
		2.3.2	RiO version 5 to be rolled out	Spring / Summer 09	KG
		2.3.3	Electronic staff record fully implemented and used	March 09	?
2.4	Productivity improvement	2.4.1	First service line analysis of costs, activity, outcomes and quality	Aug 08	Done  PG initially then

		Action no	Actions	Timing	By whom
		2.4.2	Programme of more detailed service analysis – separate work programme to be drafted to include; <ul style="list-style-type: none"> <li>Identify workstream leads &amp; set up steering group</li> <li>Analysis of “next level down” service components</li> <li>Reorganisation of components into care pathways</li> <li>Liaison with commissioners &amp; partners</li> <li>Redesign &amp; development plan for each service</li> </ul>	Sept-Mar	HBM/ SI/TIA/ Workstream leads
		2.4.3	Further work on productivity – diary analysis for a number of services	Dec 08	?contract out
2.5	Performance management	2.5.1	Balanced scorecard of KPIs in place, regular SLA meetings with commissioners. Strengthen clinical quality indicators.	Sept 08	Done
		2.5.2	Action plan to implement Ami David report	Aug-?	AD, overseen by Prov Dev Cttee
		2.5.3	Performance overseen by Provider Development Committee	From Sept 07	Done
2.6	Estate management	2.6.1	Current information in place on condition of estate	In place	Done
		2.6.2	Estate plan updated in March 2008 for development of estate	March 08	Done
		2.6.3	Determine proposed responsibility for estate under APO arrangements – subject to formal consultation	Nov-Mar	AD/AE/ Board
<b>3</b>	<b>People</b>				
3.1	Workforce management	3.1.1	Vacancies, sickness and turnover included in balanced scorecard and used to inform planning	Sept 08	Done

		Action no	Actions	Timing	By whom
		3.1.2	Develop workforce strategy for transformation plan	Nov 08	PG/GT overseen by Prov Dev Cttee
		3.1.3	Implement workforce strategy including recruitment, retention, skills development for APO and final organisation	Nov-Mar	PG/GT
3.2	Staff engagement	3.2.1	Staff engaged in process leading up to discussion document	Jan-Jul 08	Done
		3.2.2	Wide engagement of staff in discussion process: events, drop-ins, feedback forms, meetings etc	Sept-Oct 08	Done
		3.2.3	Feedback response to discussion points, and use response in determining final proposals	Oct 08	PG
		3.2.4	Formal consultation with staff engagement	Dec-Feb	Done
3.3	Talent management	3.3.1	Universal staff appraisals and personal development plans in place. Monitoring needs to be done by Business Coordinators	In place	Done
		3.3.2	Identify good and poor performers and put in place development programmes as appropriate	?	?GT
3.4	Staff resource: Finance	3.4.1	Assistant Director of Finance dedicated to provider arm	In place	Done
		3.4.2	Provider Development Programme Accountant in place	Dec 07	Done
		3.4.3	Recruit Transformation Programme Accountant	Sept 08	ES

		Action no	Actions	Timing	By whom
		3.4.4	Ensure resource for financial accounting aspects of APO	Sept 08	Done
		3.4.5	Move to more formal separation of roles, to an APO "Director of Finance" position	Apr 09	AD/AE
3.5	Staff resource: Project management	3.5.1	Provider Development Programme Manager in place	Nov 07	Done
		3.5.2	Recruitment of Transformation Team (Programme Manager, Programme Accountant, Information Analyst, Programme Coordinator), plus OD role, resource available through to Mar 2010	Sept 08	HB – done except for Information Analyst
3.6	Staff resource: Clinical skills	3.6.1	Include in workforce strategy to support transition to proposed new service model	Nov 08	PG/GT/AW
		3.6.2	Implement workforce strategy to recruit for APO	Nov-Mar	PG/GT/AW
3.7	Staff resource: Productivity and improvement	3.7.1	Recruit information analyst for provider development team (resource available)	Nov 08	PG/DB
3.8	Training students	3.8.1	Training systems in place, need reviewing for fitness for purpose in respect of new service model	Nov-Dec 08	GT/AW
<b>4</b>	<b>Finance</b>				
4.1	Income	4.1.1	Full understanding of current income streams and drivers in place	Aug 08	Done & ongoing

		Action no	Actions	Timing	By whom
		4.1.2	Develop initial strategy for diversifying and increasing income – link to development of business plan	ongoing	HBD/ES with Prov Dev Cttee oversight
		4.1.3	Assess impact of move to cost and volume (see 4.3)	Nov 08- march 2010	HBD/ES/CC/SI
4.2	Percentage of income from host PCT	4.2.1	Understanding of current split of income between host PCT and other sources	Mar 08	Done
		4.2.2	Develop plan to reduce dependence on single commissioner (4.1.2)	Jan-Mar	HBD/ES
4.3	Contracting	4.3.1	Participation in DH PbR pilot – develop proposed tariff for intermediate care	Oct 08	PG/SI
		4.3.2	In discussion with commissioners put programme in place to develop costs per unit of activity and phased move to activity based pay as activity data becomes robust	Nov 08- Mar 2010	HBD/SI/ TIA
4.4	Costed service lines	4.4.1	Service line analysis of costs per unit of activity	Aug 08	Done
		4.4.2	Further analysis needed as in 2.4.2	Sept - Mar	As above
4.5	Overhead allocation	4.5.1	Site and corporate overheads allocated based on analysis of each service line	Aug 08	Done
		4.5.2	Further refinement needed based on actual allocation of corporate services for proposed new organisational form and on	Jan-Mar 09	SI

		Action no	Actions	Timing	By whom
			the SLAs for corporate services		
4.6	Cost efficiencies	4.6.1	Development plan to be put in place for each service as in 2.4.2	Sept - Mar	As above
4.7	SLAs for back office services	4.7.1	Develop SLAs for: Quality & Professional Development HR & Corporate Affairs Finance Estates & FMS ICT Public health	Sept-Dec 08	AD and other Directors
4.8	Separation of balance sheet	4.8.1	Discussion and decision on how assets will be split	Sept-Dec 08	AD/AE/ Board
		4.8.2	Separation of balance sheet	Jan-Feb 09	AD/AE/CC
4.9	Audited accounts	4.9.1	Plan for preparation of separate audited accounts	On launch of APO	ES
4.10	Financial advice on APO and new organisation	4.10.1	Tender for financial advice on implications of final organisational form	Jan – March 09	ES/HB
		4.10.2	Seek advice as required during transformation process	Dec 08 - Mar 2010	ES/AD/ PG
<b>5</b>	<b>Governance</b>				
5.1	Provider	5.1.1	Provider Development Committee in place with Non Executive	Sept 07	Done

		<b>Action no</b>	<b>Actions</b>	<b>Timing</b>	<b>By whom</b>
	services Board	5.1.2	Chair and delegation of provider arm responsibility Set up Scheme of Delegation for APO Board	Sept-Nov 08	AD/UD/Board
		5.1.3	Set up required sub-committees to APO Board to ensure full responsibility for provider arm (audit, risk, governance, workforce etc)	Jan-Mar 09	AD/UD/Board
		5.1.4	Ensure no conflict of interest between membership of APO Board and PCT Board	Jan-Mar 09	UD/Chair
5.2	Organisational form option appraisal	5.2.1	Review options following discussion period	mid Oct	Done
		5.2.2	Discussion at Board seminar	end Oct	Done
		5.2.3	Final shortlist of options and criteria for option appraisal agreed by Board	6 Nov	Board
		5.2.4	First option appraisal of shortlisted options to Board	by 14 Nov	AD/HB
		5.2.5	Board considers option appraisal, signs off and requests management team to do further work on recommendation of final option	20 Nov	Board
		5.2.6	Agreement of final option for formal consultation	Jan 09	Board

		Action no	Actions	Timing	By whom
		5.2.7	Formal consultation on organisational form, governance, structure, service model and range of services delivered	Jan-Mar	Separate work plan to be prepared - PG Board
		5.2.8		Final decision on APO status	
5.3	Top team skills assessment	5.3.1	Develop and agree framework for OD plan	Nov 08	UD
		5.3.2	Skills assessment for Director and ADs in PCCSD and other appropriate senior staff	Dec-Jan 09	UD
		5.3.3	Development programme for staff based on assessment findings	Feb-March 09	
5.4	Legal advice on APO and new organisation	5.4.1	Procure advice for options appraisal from existing Capsticks contract	Sept	Done
		5.4.2	Tender for legal support to transition to new organisation	Nov	PG/HB
		5.4.3	Seek advice as required during transformation process	Dec-Mar 2010	AD/PG
<b>6</b>	<b>Quality and safety</b>				
6.1	Clinical safety	6.1.1	Good PCT current performance against Healthcare Commission standards	Mar 2008	Done
		6.1.2	Specific provider declaration against Healthcare Commission standards	Mar 2009	GB
		6.1.3	Clinical governance procedures specific to provider arm to be put in place (link with 5.1.3)	Jan-Mar 09	GB/AD/ Board

		<b>Action no</b>	<b>Actions</b>	<b>Timing</b>	<b>By whom</b>
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6.2	Quality metrics	6.2.2	Outcome and quality data included in balanced scorecard	Sept 08	Done
6.3	Patient satisfaction	6.3.1	Patient survey to be undertaken covering all community services and results fed into planning process	Nov 08	PG
		6.3.2	Market research on Fit for the Future proposals to be done and results fed into planning process	Sept-Oct	Done
		6.3.3	Equality Impact screening done on Fit for the Future proposals	Sept	Done
		6.3.4	Equality Impact screening done on Fit for the Future process	Sept	Done
		6.3.5	Equality Impact screening done on options for organisational form	Nov	PG/SIs
		6.3.6	Full Equality Impact Assessment done on formal consultation proposals	Jan-Feb	PG/SIs

## **PCT Community Services**

### **FURTHER DEVELOPMENT OF LAMBETH PCT COMMUNITY SERVICES INTO A NEW ORGANISATIONAL FORM**

#### **1. Summary**

The accompanying section Appendix F (i) sets out the proposal for the PCT's directly managed services to become an Autonomous Provider Organisation with effect from 1<sup>st</sup> April 2009. This will be an organisation within the PCT but with a delegated governance structure and acting with a high degree of autonomy. This paper covers the further work to be undertaken in order that the Board can consider the final preferred organisational form for the PCT community services.

The Fit for the Future discussion document set out service models, a set of criteria for considering future organisational arrangements and a long list of potential organisational forms. At its seminar on 24 October 2008, the Board discussed the feedback from staff, users and partners. The conclusions made at the seminar were that, based on the feedback received so far, further work should be done on a shortlist of 4 options (see section 7 below). This further work should include an appraisal, based on the criteria consulted upon, in order to support the Board in its decision making process. The Board will however need to take all considerations into account in coming to its final view.

#### **2. Context**

The background and context for making these changes is set out in the accompanying paper on creating an Autonomous Provider Organisation. A more independent community provider organisation will offer opportunities for community provider services to deliver to their potential, to innovate and excel in what they are good at. It will also enable the PCT as a commissioner to strengthen and develop to become world class in its commissioning. The feedback that we received from staff, partners and users was broadly positive to the development of greater autonomy and independence for the directly managed community services.

#### **3. Feedback from the Fit for the Future discussion document**

A summary of the feedback from the recent Fit for the Future discussion document and associated staff events, bilaterals and market research with users is at Annex C. This includes an aggregation of weights given by staff and partners to the criteria included in the document. Weights based on user feedback and deliberations by the Board have also been included.

Key feedback to come out of this discussion process is:

- There is a high degree of support from staff, partners and service users for the service models outlined in the discussion paper (for Children's Services, Adult Community Services and Primary & Planned Care

Services), aimed at making it easier to deliver services along care pathways.

- Staff would like the future organisation to preserve staff rights to NHS terms and conditions, in particular pensions.
- The future organisation must allow staff to have full access to training and professional development, and to participate in local NHS networks for professional development and research.
- It must have, or be able to use, the NHS brand – this is important to both staff and patients.
- There must be close working and functional integration with local authority functions, particularly for children’s services, but neither PCT staff nor London Borough of Lambeth are keen on organisational integration.
- There must be close involvement from GPs with the future organisation, but there are mixed views from GPs about integrating with/managing the provision of community services. No single model has come out, and no clear view on how it would work. An integrated organisation with GPs would require major energy, proactivity and leadership from them.
- A community services provider should be rooted in Lambeth and with Lambeth as its first priority, but should also be able to take on service provision in other areas where appropriate, provided this does not adversely affect the quality of provision in Lambeth.
- The Academic Health Sciences Centre registered their interest in the option to integrate with an existing NHS organisation and asked that this be kept open as an option.

#### **4. Vision for the future of Lambeth Community Services**

A key component of the future development of community services in Lambeth has been a debate about the vision for the future. We asked for feedback during the Fit for the Future discussion and having listened carefully to the feedback from our staff, our users and our partners in the Fit for the Future discussion, the provider services has further developed its vision for the future of community services in Lambeth.

We wish to create a strong and successful provider of NHS community health services in Lambeth that has the freedom to operate in a more business like way and where the senior clinical and managerial leadership teams are fully focussed on service improvement, innovation and provision of high quality services where improving access and delivering services along care pathways are a priority. We want to create an organisation that is focussed on meeting the health needs of the diverse local Lambeth community, that is rooted in Lambeth and that has the Lambeth community as its first priority for the delivery of core community services. We see the organisation as being an employer of choice, particularly within the local community in Lambeth. We

need an organisation that is vibrant and confident in its own right and that has a strong and close working relationship with its allies, in particular local GPs, our partners in the local authority and others with whom we work to deliver services along the care pathway. Crucial to this will be to further develop and strengthen our localities as our partner organisations increasingly align themselves with these. We also see the organisation as being outward looking and one that is able to take opportunities to further develop the provision of specialist services to communities beyond Lambeth where appropriate, provided this does not adversely affect the quality of provision in Lambeth.

Clearly, further work needs to be done to test out the vision and to ensure that this fits with the views of our commissioners. This work will continue through the winter and spring.

## **5. Future service models**

There was broad support for the service models set out in the Fit for the Future discussion document which was that the community service provider would work along care pathways being very clear about what its delivery arrangements are for assessment, care planning and care delivery. The aim would be to ensure that there is a clear understanding for both the patient and the care provider that a particular care pathway is being followed which is based on evidence, that choices can be made if appropriate at particular stages and that it is clear why other professionals are being involved and what those people are there to do.

It is anticipated, subject to the formal consultation phase, that services will be organised along care pathways. Early thoughts are that the APO and therefore the subsequent organisation could be organised along care groups while ensuring that the locality focus is maintained for the core community services e.g. health visiting, district nursing and some speech and language therapy.

The groups or directorates could be as follows:

- Childrens services with the following care pathways: universal, vulnerable, neurodisability, complex.
- Adult services with the following care pathways: long term conditions, neurodisability, complex disability and inpatient services. This care group could also include a hospital at home pathway.
- Planned and primary care offering walk-in services, outreach and service development, planned specialist services.
- Business development, finance and support functions.

Further discussion and consultation will be required but there will an imperative to ensure strong clinical and managerial leadership to the new way of working.

## 6. Criteria for deciding on the future organisational form

The Fit for the Future discussion included asking for feedback on criteria that the Board can use to inform and steer its decision about the future organisational form for community services. Following the feedback received, four additional criteria have been added to the ones listed in Appendix F of the discussion paper. These are:

- Ability to meet statutory responsibilities (particularly for children's services)
- Economic viability and sustainability
- Minimising the disruption to services
- Impact on commissioning (particularly the PCT's progress in becoming a World Class Commissioner)

We have also grouped the criteria into four key themes. The full list of criteria for informing and steering a decision on the future organisational form is now proposed as follows:

	<b>Criteria related to recruitment, retention, NHS terms and conditions, staff involvement</b>	<b>Combined weight</b>
1	Able to recruit & retain high quality staff (with particular regard to terms and conditions and access to NHS pensions)	4.8
2	Staff involved in governance	4.5
3	Potential for career development	4.1
4	Links with research & academia	3.4
5	NHS status	4.7
6	Minimise degree of change required	4
	<b>Criteria related to meeting population's diverse needs and their preferences</b>	
7	NHS brand	4.4
8	Allows for choice and convenient access times	4.3
9	Framework to increase quality and improve health of population	4.4
10	Meets needs of vulnerable groups	4.7
11	Grounded in Lambeth	3.8

	<b>Criteria related to supporting the development of a viable and sustainable business</b>	
12	Wide range of services	3.7
13	Flexible & supports innovation, eg through retention of surpluses	3.9
14	Robust and stable	4.6
15	Strong connections with GPs	4.6
16	Ability to meet statutory responsibilities	5
17	Economic viability	5
	<b>Leverage and opportunities for the development of excellent services</b>	
18	Opportunities for joined up care	4.0
19	Services recognised as excellent	4.7
20	Strengthens clinical leadership/clinically driven	3.8
21	Strong community & service user involvement	4.3
22	Strong connections with local authority	3.6
23	Strong connections with hospital & mental health services	3.3
24	Impact on World Class Commissioning	5

Note: combined weight takes into account feedback from staff, partners, users and the Board.

The full list and the weights are based on the feedback from staff, users and partners and discussed with Board members.

## **7. Shortlist of options for organisational form**

The Fit for the Future discussion paper had a long list of options for organisational form at section 4(c). At its Seminar on 24 October 2008 the Board carefully considered the feedback it had received and the implications for organisational options. Based on this, the Board felt that some of these options were not appropriate to pursue further and that a shorter list of possible options should be taken forward for more in depth work and appraisal based on the final list of criteria, the guidance due to be issued in December and further debate and discussion with the Board. The short list of organisational options that emerged from the discussions at the Board seminar is as follows.

	Option	Brief description
Option 1	Remain as Autonomous Provider Organisation (APO) within the PCT (dependent on further discussion with NHS London)	An organisation within Lambeth PCT but one that operates with a delegated governance structure and acting with a high degree of autonomy.
Option 2	Community Foundation Trust	A new type of NHS organisation established as independent public benefit corporations to be regulated by Monitor. Creation of an APO is a key first step. Note: the first wave of CFTs are likely to go live in 2009/10.
Option 3	Community Interest Company (in form of a company limited by shares, with all shareholders being NHS employees and/or GPs)	A limited company with special features created especially for social enterprises or business focussed on profit for community benefit. It has the potential to qualify as an "employing authority" for NHS pension scheme purposes.
Option 4	Integrate with another NHS Foundation Trust eg Guys & St Thomas', Kings, SLAM or another	A separate Directorate or fully integrated services as part of a local NHS Foundation Trust

Under all of the above, links with the Academic Health Sciences Centre being developed by GSTT, Kings and SLAM are considered important.

## **8. Option appraisal**

At the request of the Board, the Management Team is undertaking an initial option appraisal of these 4 shortlisted options for further consideration by the Board.

## 9. Recommendation

The Board is asked to:

- Agree the criteria and weights used to complete an initial option appraisal on 4 options that will inform and steer the debate on future organisational form
- Agree that a future community services organisation will operate according to the broad service models outlined in the Fit for the Future discussion paper
- Agree that the PCT Management Team should work up proposed structures for the community services organisation to achieve these service models, for formal consultation

## Fit for the Future Discussion Document: Initial Summary of Feedback

### 1. Introduction

During the early Autumn, Lambeth PCT held a discussion with staff, partners and users on its Fit for the Future proposals about future arrangement for the provision of community services in Lambeth. This paper provides an initial summary of the feedback and includes: the engagement we undertook during the discussion period; a summary of responses received from staff, GPs, partners e.g. the Local Authority, other NHS providers and the voluntary sector. It also includes user feedback from market research commissioned from TNS. Further work on the more detailed responses we received is ongoing.

### 2. Engagement during Discussion Period

#### 2.1. Staff

People signed in at staff events	182
Drop ins	56
Primary Care Commissioning Workshop	17
Team Meetings attended:	LCCC
	Pulross
	Adult Therapies
	School Nursing – SW
	Health Visiting – SW
	Foot Health
	Mary Sheridan Centre
	Geriatricians

A total of 47 feedback forms and 181 questionnaires were received.

#### Service responded:

Business coordinators  
Administrators  
Customer Services  
Adult therapies  
3 Boroughs  
Sickle Cell & Thalassaemia  
Community Nursing  
Intermediate Care  
Minnie Kidd  
Nutrition and Dietetics  
Foot Health  
Eneuresis  
Clinical Audit  
Child Health Service Managers

#### Response from:

Individuals  
Individuals  
Individuals  
individuals and teams  
individuals and teams  
individuals and team  
Individuals  
individuals and teams  
Team  
Individuals  
team and individuals  
Team  
Team

Sexual Health – Health Promotion	
School Nursing	individual and team
Child Protection team	Team
Community Paediatrics	individual and team
Health Promotion	Team
Health Visiting	Individual
Specialist Child health paed	individual and team
Community Geriatricians	Team
Public Health – infection control	Team
Primary Care Partnership Managers	Individuals
Assistant Directors Primary Care and Community Services	
Children Physio	Individual and team
Children SALT	Team
LAC	Team
TACT & Rapid Response	Individual
Primary Care Commissioning staff	Individual and team

## 2.2. Partners

GP workshop attendees	20
Voluntary agency workshop attendees	18
Bilaterals:	Kings & Guys and St Thomas' SLaM Children and Young People's Services Adult and Community Services

50 feedback forms were received from partners

Of which:		
	GPs	13
	Voluntary agencies	2
	CYPS assembly	29
	CYPS	1
	Optometry council	1
	Social Services	1
	AHSC	1
	Local Dental Committee	1
	PEC	1

## 3. Summary of Responses

## **Staff:**

### **Proposals for service models:**

- More clarification needed on general model
- Responses are generally positive and supportive, particularly of plans for co-location, with queries around practical details of implementation.
- Some worry around separation of professional groups, lack of clarity about where clinical leadership would come from, decreased opportunities for career progression, weakening of the clinical governance system, loss of economies of scale within current service teams.
- Need for flexibility emphasised.
- Suggestion from community paediatricians: The general model for all services should be expanded to include a) prevention b) identification c) assessment d) interventions f) long term support. This could provide a child & family pathway through universal services to specialist community, CAMHS and hospital child health and will be effective in reducing demand on acute services.
- Build in clear and strong leadership, service improvement, workforce development and business/performance capacity as part of every day business.

### **Transition**

- How will services work for boundary users, e.g. teenagers?

### **Estates and Location of services**

- Where would such large centres (as in Children's Specialist services) be housed?
- For universal services - need to retain option to deliver borough-wide service if indicated by need

### **Working relationships**

- Will the current personal relationships between managers and staff be lost in a larger structure?
- Important to improve inter-service links, but also maintain/improve those with the acute sector.
- Community staff are very small in number- there is a fine balance between efficiency in deployment of 'numbers' and providing appropriate expertise to specific specialist needs. This presents a major workforce development issue and the need to retain large groupings of staff 'together' to maximise flexibility and potential to develop a range of expertise in different staff members which can align to the relevant care pathways

### **IT and Information**

- Need for good integration of IT across the organisation, as well as good information record systems.

## GP Relations

- Relationship with GPs is to be considered: not wanting to merge with GPs vs. need for close ties. Not wanting to lose links with primary care.

## Defining the 'pathway'

- Support for care pathways to be developed to respond to client need. Must be led by client need rather than staff need.
- Separation of assessment, planning and delivery – fear of creating a bureaucratic process and losing care continuity. Fragmentation of care also a preoccupation with decision on whether to 'make or buy'.
- Different care pathways are often interdependent (e.g. safeguarding, looked after and disability), and patients constantly cross boundaries.

## Service-specific concerns:

- **Refugee Team:** Where do refugees fit within these service models and how do they work with the Refugee Health Team LSL?
- **TB team:** In the Children's Model TB team not incorporated as a link for BCG. Adult model- not included in proposal. P&P Care - TB Team provides service to HTR group and has been omitted. There is the need for a referral pathway under one management.
- **Sickle cell:** Strong feeling that dividing this service across child and adult sites would be detrimental to coordination of treatment, particularly in transitional (teenage) phase. Structure is already clearly defined and works, as everyone including business support staff know the service well. Would they be lost with proposed changes? If all child services and all adult services will be placed together, This will split the sickle cell and thalassaemia team. Currently the team work all together at wooden spoon house, any problems can be discussed regarding clients quickly and effectively, team leaders and the service managers are easy to locate due to being in the same building complex issues can be discussed and decision can be made how to manage the case more effectively to prevent delay. Also the team leader works closely with case managers regarding teenagers who need to transition into adult care. As the team leaders have looked after many of the teenagers since birth, they are a source of expert advice regarding the client. If the service becomes separated I would also be concerned for our clients having to find their health professional in different area, they have always known the service to be together, separating the service will cause stress and confusion and information may not be passed on as smoothly.
- Dilution of specialist staff and loss of economies of scale provided by the team of nurses and business support staff in the current model; loss of ability to draw on the experience of an expert team as a whole.
- Clarification is needed regarding sickle cell services as these include 1) screening & counselling services to a well population and 2) support for those who have disease and this distinction has not been made in the document. The future could be very different for the different parts.

- With the stated rationale, there is strong feeling among the team members for the service in its entirety to sit in Primary and Planned Care arm/model of the new organisation.
- **Nutrition and Dietetics:** Greater links with midwifery and GPs would be helpful for nutritionists to establish a continuous relationship with families, given the increasing number of births in Lambeth and the impact of early nutrition on risk of adult diseases.
- What would the **school nurse's** role be in practice?
- **PC&CS:** have been working on improving clear care pathways between specialist and generalist providers for some time.
- **Patients with disabilities:** Does this model go against the integration of disabled children/adults in society (services for clients with disabilities grouped under 'specialist').
- **Children's Services MSC:** We would be concerned with the proposal is put forward without further exploration around how the developmental and vulnerable needs of the child population are addressed. A significant number of children in need that currently receive child health services do not meet the eligibility criteria for accessing social care provision. Further consideration would be required to look what are the shared definitions/descriptions of the terms used to describe the suggested groups of children suggested for an integrated service. E.g. Disability, Special Needs.
- We feel that CAMHS could support universal and targeted services better with locality working, integrated with child health. The current model omits 'targeted' services.
- Reality of integrated services: We provide a range of services to children in partnership with the council and continue to develop services in partnership with a range of colleagues within the local authority; however, we must be mindful that we have equally strong partnerships with our colleagues across the health economy.
- We recommend strongly that there is a director for children who operates at board level. Consideration should be given to appointing a public health paediatrician (or joint appointment) to support the provider function
- We wish to remain a training organisation that attracts high calibre trainees.
- Need for an experienced senior manager who is a champion for children.
- We would support children's community care nursing (currently managed by Lewisham PCT) being integrated into the Lambeth children's disability nursing team. We would also like the secondary audiology service to include those children living in 'East' Lambeth (currently being provided by Kings) as there is confusion and inequity for the children of Lambeth.

## **Proposals for range of services:**

### **Definition of core business**

- Strong desire for this definition to come naturally from a pre-defined 'vision' which inspires pride in the communal effort.
- Need a stronger sense of a vision for the future or a suggestion of options for a vision of the future, for community health services in Lambeth.
- General feeling that wording should be clearer, but that content is along the right lines.
- Debate as to whether core services should be offered to GP registered population or just residents. Need for clarification here.
- Should training and development be included?

### **Grouping of services**

- Generally positive response with some requests for adjustments from particular teams.
- Negative reactions to groups E and F.
- **Child services:** The groupings created for children's services do not represent the range of care pathways that are delivered. We do not feel that it is a rigorous analysis of what future business should look like. The grouping and services table indicates which service area will benefit from further work in order develop appropriate data, costings etc. A table of costing reflecting the universal, targeted and specialist elements of care that are delivered will be useful to helping to identify the true costs of children's services.
- Child protection as part of Group C queried.
- Group F considered untenable at the current time by community paediatricians.
- Child protection service omitted.

### **Potential new services**

- Requests for diagnostic services in clinics to avoid trips to hospitals for minor problems.
- Health promotion services a suggested priority.
- Some positive response to idea of private provision on top of existing services.
- Improving core services needs to happen before expanding services.

### **Future of primary care commissioning**

- Opinions in both directions on whether commissioning should stay with community services or move to commissioning body. Staying with community services possibly more popular due to successes with current arrangement.
- Problem of re-positioning roles which currently straddle commissioning and providing.

### **Possible organisational forms:**

- More information needed before real votes can be cast. Generally a need for better understanding of services, costs, quality, service aims and outcomes.
- APO status seems to appeal as a sensible middle ground.
- Loss of autonomy and funding feared in idea of integration with GPs or Acute or Mental Health Trusts, though current relations are described positively. Could integration be functional rather than structural?
- Community NHS Foundation Trust popular with some.
- Changes should be kept to a minimum – management structure not what affects patient experience most. The most basic problems more important. Investment should go to stronger administration and information services above all.
- Integration with LA generally unpopular. Concern around politicisation and misunderstanding of complexities of healthcare. Important to ensure that health outcomes are safeguarded in whatever model is eventually chosen.
- General desire to remain within the NHS. Nervousness around loss of NHS terms and conditions, pensions, as well as training and professional development networks.

### **Other comments**

- Need for resource-consuming training to be reflected in costings.
- Investment should go to stronger administration, information services and data analysis above all.

### **GPs:**

#### **1. Proposals for service models:**

- Concern that separation of assessment/plan/delivery will fragment the service for the user.
- Maintain locality focus
- Need to manage transition phase.
- For children services - specialist needs to integrate with locality teams, moving around to do so where necessary
- For adult services – fear that patients who do not fit a care pathway neatly will slip between the cracks.

#### **2. Proposals for range of services:**

- Need for consistent cross-boundary agreements, i.e. whether core services should be offered to GP registered population or just residents.

### **Potential new services**

- Better to improve core services (e.g. district nursing and health visiting) than provide many different services of low standard. This stands against introduction of expensive new services, e.g. ultrasound and X-ray.
- Need for expansion of health promotion.
- Need for IT training and development in community services.

### **Future of primary care commissioning**

- Views on this have been divided, with some in favour of moving this to the commissioning arm of the PCT.
- GPs need to be able to influence commissioning according to local need. Should not become remote from the community or from community services.
- Effect on services covering three boroughs would need to be considered in any change.

### **3. Possible organisational forms:**

- Informal integration positive, but not formal integration with acute, LA or other PCTs.
- Need for relationship with GPs, particularly for health visiting and school nursing, to be close. Some localities interested in integrating with/managing these services, others only want to commission.
- Formal organisational restructure seen as waste of resources and not most relevant issue for improving services for user. Keep unnecessary changes to a minimum.
- Recruitment and retention is priority: strive for staff satisfaction in any change.
- Stand alone organisation probably least problematic.

### **Local Authority:**

#### **CYPS**

- No wish for organisational integration. More interested in functional integration.
- The need for building on already established partnership working between Lambeth Council Children Services and the PCT e.g. TACT, as highlighted by recent JAR inspection.
- Access to service pathways need to be as clear as the medical care pathways.
- Support for APO in allowing opportunity build on achievements and achieve excellence in all services.
- Options appraisal of each organisational model including risk assessments and support of Children's Act 2004.

- New organisational form must support direction of travel agreed by CYPS e.g provision of services by locality and ongoing development of TAC.

### **Adult & Community Services**

- Highlight the need for continual discussion re future organisational form to ensure support on any final decisions.
- Any future organisational form should build on the successes around current successful partnership working and integrated, aligned service delivery.
- Clarification on governance structures to support the separation of Provider Services. Keen to ensure senior office representation on bodies established as a result of proposals.
- Welcome move to disaggregate provider and commissioning functions. Consideration for the role of the Local authority as a commissioner and joint commissioner with commissioning arm of PCT.
- Risk analysis of options for organisational forms under consideration.

### **Children Assembly meeting**

- Concerns raised about centralising the specialist services, especially around accessibility for vulnerable groups. Idea of localised central hubs to fit in with locality model.

### **Academic Health Sciences Centre: Encompassing GSTT, KCH, KCL and SLaM**

- Strong support for reshaping and integrating services along patient pathways and supporting patients to stay at home where possible. Note of concern to ensure engagement of key clinicians to ensure genuine joint working and facilitates shifting care
- Support for integration with mental health services in the community, possibly having mental health professionals as part of community teams.
- Adult & Elderly services – potential for link with Acute Trusts to facilitate better links between acute stays and discharge pathways
- Supports direction of travel of separation of provider function from commissioning function within the PCT.
- Supports primary care commissioning sit within the broader commissioning function
- Wish for option D (integration with acute/mental health) to remain open.

### **Voluntary Agencies**

- Support for central location for specialist children services. Support for Adult & Elderly as well as Primary & Planned Care but advocates for involvement of client so that models are based on clients needs.

- Interested in potential for them to be able to bid for services being tendered out through the commissioning arm of the PCT.

#### **4. User Feedback from TNS Market Research**

##### **What is important to users?**

##### **High Priority**

##### Lambeth PCT is listening

- Contact number for information
- Staff with strong listening skills
- Need to feel empowered and involved in treatment

##### Accessibility of services

- Waiting times for being seen or time waiting for a pre booked appointment
- Extended time for access to services particularly on Saturdays
- Follow up and after care after using a service

##### Meeting the needs of the vulnerable

- Acknowledgement of Lambeth's high numbers of vulnerable residents
- Need to look at all vulnerable groups not just elderly, multiple conditions, young people etc.

##### **Medium Priority**

##### Focused on preventing disease

- Key priority for youth especially around issues such as sexual health, nutrition etc

##### Partnership working

- Remove the need for patients having to be articulate and assertive to get professionals talking
- Liked model of services being based in one place.

##### Range of community services

- Lack of awareness of range of services on offer
- Some services envisaged as part of hospitals or GPs
- Request for list of services to be made available e.g. when patients register with a GP

##### **Low Priority**

##### Lambeth knows its residents

- Acknowledge diversity

##### Sharing resources across boroughs

- Borough should be self sufficient and services reflect need of borough
- Might consider local area rather than the boundaries of Lambeth

### Consistent level of treatment

- Deemed a given that services will be high quality and consistent

### **New Services:**

- Support for polyclinics
- Positive re hospital services in the community e.g. x-rays. Concerns re equipment being up to date
- Hospital at home useful mainly for those with stable conditions, the elderly or end of life care. In the case of children could put great responsibility on parents
- Walk in centres had mixed reactions. Benefit of accessibility after hours but may not work for more elderly etc who are attached to their GP.
- Health trainers / coaches seem less important area

### **Service models:**

- Huge appeal for children's model. Should be made similar for adults
- Point of contact critical for success

### **Organisational Structure:**

Stand alone:

- Prefer structure joined to another
- Huge pride in NHS brand
- Private or not for profit services seen as a drain on NHS funds

Community services and GP:

- Resembles what they think already happens
- Seen as having the strongest links
- Concern over GPs being overstretched and potential impact on community services

Community services and hospital:

- Not preferred

Community services and Local Authority:

- Adverse reaction based on strong mistrust of social services by some.
- Support for close working
- PCT taking over some Local Authority services?

31 October 2008

## ANNEX D

**OPTION APPRAISAL FOR FUTURE ORGANISATIONAL FORM OF  
LAMBETH PCT COMMUNITY SERVICES****1. INITIAL SHORTLIST OF OPTIONS**

The initial shortlist of organisational options has been developed using key points to come out of the Fit for the Future discussion process and following discussion at a PCT Board seminar in October 2008. These are:

- The future organisation must be able to retain existing staff and be successful at recruiting new staff. Feedback from staff highlighted the importance to them of NHS terms and conditions, in particular pensions.
- The future organisation must allow staff to have full access to training and professional development, and to participate in local NHS networks for professional development and research.
- It must have, or be able to use, the NHS brand – important to both staff and patients.
- There must be scope for close partnership working and functional integration with local authority functions, particularly for children's services, but neither PCT staff nor London Borough of Lambeth are keen on organisational integration
- Close involvement from GPs with the future organisation was important, but there are mixed views from GPs about integrating with/managing the provision of community services. No single model has emerged from the GP feedback, and no clear view on how it would work. An integrated organisation with GPs would require major energy, proactivity and leadership from them.
- The future organisation should be grounded in Lambeth but there it must also be able to be outward looking to continue to develop and offer specialist services outside Lambeth
- The future organisation must be set up in a way that ensures it is economically viable and sustainable in the longer term
- The arrangements for the provision of community services must compliment and support the work of the PCT to develop as a world class commissioner.

From the above and based on a discussion at the Board seminar held on 24 October 2008, a shortlist of options were agreed for more indepth work and appraisal based on the final list of criteria, the guidance due to be issued in December and further debate and discussion with the Board. The option were:

Option 1	Remain as Autonomous Provider Organisation (APO) within the PCT (dependent on further discussion with NHS London)
Option 2	Community Foundation Trust
Option 3	Community Interest Company (in form of a company limited by shares, with all shareholders being NHS employees and/or GPs)
Option 4	Integrate with another NHS Foundation Trust e.g. Guys & St Thomas', Kings, SLAM or another

Under all of the above, links with the Academic Health Sciences Centre being developed by GSTFT, Kings and SLAM are considered important.

## 2. OPTION APPRAISAL

### Method

The option appraisal methodology which follows is based on joining together the criteria from the staff questionnaire and the partner questionnaire. There is a small amount of overlap between the two. The Fit for Future discussion document has been screened for equity and equality which included the criteria.

The scoring column, yet to be completed, will represent how well each organisational form scores against each of the criteria. This appraisal will inform and provide a steer for the Board in its ongoing deliberations about future organisational form.

The weight columns show how staff and partners rated each of the criteria in terms of importance. The figures shown are averages from the questionnaires returned.

Service users did not allocate weights to the criteria in the market research, but did indicate whether they thought they had high, medium or low importance. We have allocated scores of 5, 4 and 3 to each of these, in order to put them in the same broad range as the staff and partner weights.

We have added weights for the PCT Board based on a discussion of what were important factors for them in considering the future of community provision.

The combined weight is a straight average of staff, partner, user and Board weights.

The weighted score will be derived from multiplying the score and the combined weight. In doing the analysis it will be possible to compare the results for each of the 4 groups. However, we believe that looking at the combined score will give a more balanced view across all the stakeholders. The scoring results will inform the Board in its work to decide on the best future arrangements for community services.

### The criteria

As a result of the discussion period and the debate at the Board seminar additional criteria have been added as follows:

- Ability to meet statutory responsibilities (particularly for children's services)

- Economic viability and sustainability
- Minimising the disruption to services
- Impact on commissioning (particularly the PCT's progress in becoming a World Class Commissioner)

The criteria are included in the main text of the report.