Department of Health

Transforming Community Services:

Enabling new patterns of provision

NHS

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Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning/	Finance
Clinical	Social Care/Partnership Working

Document purpose	Best Practice Guidance
Gateway Reference	10850
Title	Transforming Community Services: Enabling New Patterns of Provision
Author	Transforming Community Services team, DH
Publication date	13 Jan 2009
Target audience	PCT CEs, SHA CEs, PCT Chairs
Circulation list	NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, Trade Unions
Description	This enabling guidance is intended to help PCT providers of community services to move their relationship with their commissioners to a purely contractual one, consider what type(s) of organisations would best meet the future needs of patients and local communities, and how change can be managed to support the transformation of services to patients.
Cross ref	Transforming Community Services: Resource Pack for Commissioners of Community Services
Superseded docs	N/A
Action required	N/A
Timing	N/A
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For recipient's use	

First published 13 January 2009

Produced by the Department of Health

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Executive Summary

High Quality Care for All has set a clear overall vision – to make quality the organising principle for the NHS. It defines quality as spanning three areas: patient safety, patient experience and the effectiveness of care. These three things taken together will make a quality service. This will require transformational change – by clinicians and other front-line staff, by the organisations providing community services and by commissioners.

Our vision for primary and community care[1] made a public commitment to creating modern, responsive community services of a consistently high standard. We believe that this is what patients and communities need and deserve, and what staff want to deliver.

This is why we have placed quality and enabling transformational change at the core of the Transforming Community Services programme. We have already begun to co-produce with the NHS a Quality Framework for community services. This is being designed to reflect the particular circumstances and challenges of community services. An equally high priority is enabling transformational clinical practice – disseminating best practice and investing in developing clinical and leadership skills.

In parallel, we need to transform the commissioning of community services. We are doing this through World Class Commissioning, and by providing commissioners with the tools they need to drive service improvement – a new standard contract, guidance on costing and pricing, information and metrics.

But to secure modern, high quality community services we also need to ensure that the organisations providing them are fit for purpose. We need modern organisations, which enable and empower front-line staff to innovate and free up their time to care for patients. Organisations which empower all clinicians to shape the future of community services, and provide them with the support and resources they need to be world class practitioners. Organisations which have a robust business infrastructure, capable of contracting with commissioners and effective business planning. Such organisations also need to be sustainable and flexible – capable of evolving to meet an increasingly challenging environment of rising patient expectations, more demanding PCT and practice-based commissioners (wanting higher service quality, more effective targeting of resources to need, and better value), and increasing patient choice.

The aim of this enabling document is to help providers of community services to meet these challenges by considering what type(s) of organisations would best meet the needs of patients and local communities (informed by a thorough needs analysis), and how such change can be managed well to support the transformation of services to patients. This includes following good workforce practice, and timely and sustained engagement with key local stakeholders. Retaining skilled and well-motivated teams of clinical and non-clinical staff during a period of change will be

[1] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

a critical factor in maintaining and improving the quality of provision of services to patients. Early engagement with staff and their trade unions will be central to the success of a strategic approach to transforming community services.

There is no national 'blueprint'. Decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities. To help support local decision-making, a set of guiding principles should underpin this transformational change. These include:

- the interests of patients and carers must be paramount;
- quality is the organising principle – organisations must enable the provision of safe, effective, personalised care. This will require the capacity and capability for transformational service change;
- a pre-requisite for PCTs is a clear commissioning strategy, with improving quality and reducing inequalities at its core;
- proposals must also be able to deliver value for money for tax-payers;
- decisions about how services are provided should be led and made locally, with robust consultation processes;
- recognition that services differ in their characteristics and the people they serve, and therefore that different solutions may suit different services, even within the same locality;
- the early and continued involvement of staff, trade unions and stakeholders before any decisions are made;
- high standards of human resource management should be followed;
- assurance, approval and authorisation processes must be clear, robust and transparent;
- proposals must enable integrated care including with Local Authority services where appropriate, World Class Commissioning and patient choice;
- proposals must fit with the Department's published *Principles and Rules for Cooperation and Competition*;
- options are equality impact assessed;
- provision of safeguards for service continuity, assets[2] and staff pensions.

[2] Control of current PCT property should be protected in the interests of taxpayers and to ensure that commissioners have sufficient leverage to drive change and improve quality. As a rule, property will not be transferred to providers and PCTs will be encouraged to develop strategic partnerships that make the best use of estate.

One of the reasons for producing this guidance is the current highly variable pace of organisational change to services directly-provided by PCTs. Decisions should be led locally, but it is in everyone's interest that change is managed coherently, to high standards, and reflects the consistent application of common guiding principles and criteria. As part of good leadership and to reduce uncertainty, all PCT boards should start to engage their staff, unions, communities and stakeholders about the likely future direction for the provision of their community services.

The requirement to *'create an internal separation of their operational provider services, agree SLAs, based on the same business and financial rules as applied to all other providers'* was included in the NHS Operating Framework for 2008/09. Therefore **by April 2009 all PCT direct provider organisations should have moved into a contractual relationship with their PCT commissioning function, using the national contract for community services in 2009/10**. This means ensuring sufficient separation of roles within the PCT to avoid direct conflicts of interests.

It is anticipated that, **by October 2009**, PCT commissioners, working closely with their practice-based commissioners, will have developed a detailed plan for transforming community services, including how they intend to enhance patient choice, for agreement with their SHA. To the same timescale, PCT provider services should review (in consultation with local staff and trade unions) and assure themselves that they have the best governance arrangements to sustain high quality community services that best suit local need and circumstances, and whether to declare an interest in establishing new governance arrangements, such as a social enterprise or Community Foundation Trust.

There is a range of potential options for providing community services, from PCT provider services (which will continue to be an option where well-led, well-managed and more business-like), through Community Foundation Trusts, social enterprises for which there is a right to request, integration with other NHS organisations, and PCTs contracting with integrated care organisations, or non-NHS bodies. Different forms may suit different services and hybrid organisations derived from more standard original models may well emerge as systems evolve. *There is no prescribed ideal form and it is a matter for local determination.*

Key points for Chief Executives

> the drivers are for modern, innovative community services that have direct benefits for patients, are responsive to local need, and promote seamless care through increased opportunities for integration of health and social care services;

> there is a clear timetable for PCT provided services to move into a contractual relationship with their PCT commissioning arm, and to develop plans for transforming community services and options for future organisational forms. PCTs can move more quickly provided certain requirements are met;

> ensure clarity about the future ownership of assets;

> ensure robust arrangements are in place for staff engagement and trade union consultation throughout the process;

> the processes outlined enable a PCT to commissioning fairly, whilst developing its in-house provider to become business ready, exercise a right to request, and have "first call" in the initial stages;

> the leadership, capability and capacity of the provider sub committee needs to be of a sufficiently high calibre to take forward new patterns confidently and competently, with appropriate development programmes to enable this;

> services and business continuity must be maintained during these management changes so that patient care is not compromised;

> the SHA has a clear role in assuring the process leading to the PCT Board decision of new patterns of community service provision.

Key points for PCT Boards

> the evidence of benefits to patients and value for the taxpayer of options must be clearly demonstrated;

> decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities;

> the process is underpinned with robust governance arrangements;

> the role and responsibilities of Non-Executive Directors (NEDS) are discharged in a manner which allows them to fulfil the terms of their appointment to the corporate PCT Board;

> the inevitable split of the Board is managed in such a way to expose and manage conflicts of interest in an open, transparent manner;

> the interests of the workforce are appropriately addressed and safeguarded during the period of preparation and implementation;

> the timeframe and remuneration for the creation of new Boards as a consequence of the separation and provider market development is clarified.

1. Introduction

Objectives

1.1 The Next Stage Review[3] signalled the Government's firm intention of improving all healthcare services to achieve and sustain the highest possible quality. *Our vision for primary and community care*[4] committed to enabling modern, consistently high quality, sustainable community services that are responsive to patients and communities whilst offering value for money for taxpayers.

1.2 In realising this vision, PCTs will:

> **Make quality their organising principle** – being clear about quality, measuring quality, publishing quality performance, and recognising and rewarding quality improvement. The new national Quality Framework for community services and six transformational practice guides will be pivotal to this, underpinned, by a new standard contract and Commissioning for Higher Quality and Innovation (CQUIN)[5] for community services;

> **Empower staff to improve patient care and focus on quality** – by reshaping provider organisations for community services to ensure they are capable of meeting future patient care needs and best empower staff to improve care and transform their practice. This may mean developing new organisational forms for a new century, with staff having the right to request to set up social enterprises;

> **Enable World Class Commissioning** – by freeing themselves to focus their energies on becoming world class commissioners, with – as a minimum – their provider services at arms length and working in a contractual relationship;

> **Provide direction and strengthen leadership** – we want to give leaders, both clinical and non-clinical, the best information on prospective providers and their organisations, so that they feel empowered to make the right decisions for their community;

> **Promote patient choice** – working with practice-based commissioners to challenge existing providers to become more responsive to patient and community needs. One mechanism for achieving this may be by introducing more innovative providers within a local health economy who can offer patients more choice in deciding how they want their service provided and to meet their needs and aspirations;

[3] *Our NHS, Our Future: Next Stage Review Interim Report*, Department of Health, October 2007
[4] Department of Health, July 2008
[5] *Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework*, December 2008

- **Foster appropriate competition to drive better service quality and value for money** – applying the *Principles and Rules for Cooperation and Competition* will promote both collaboration and fair competition between different providers, driving up both quality and efficiency, using the full range of commissioning levers including the introduction of Any Willing PCT-accredited Providers (AWPP);

- **Protect assets and the interests of taxpayers and ensure flexibility** – ownership should not normally pass to providers;

- **Ensure the provision of safe, fit for purpose buildings** – which can provide quality environments for patient care and healthy workplaces for staff.

1.3 Lord Darzi made a commitment[6] to support the NHS in making local decisions on the governance and organisational models that best underpin the development of flexible, responsive community services. This document provides that support by:

- explaining the rationale for moving towards new patterns of services

- establishing key principles which should shape the choice of organisational forms

- setting out the range of organisational models available – their key characteristics, pros and cons

- highlighting some of the implications for governance, choice, competition and employment,

- describing what PCT commissioners and PCT providers need to do

- setting a timetable

- advising on key issues such as the ownership of assets.

[6] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

Who this document is intended for

1.4 **PCT Directors and Board members** who will lead the changes from the commissioning standpoint and work with their direct provider staff to identify the future arrangements for in-house provision. In doing this they will need to:

- have completed a joint strategic needs assessment and produced a five-year strategic commissioning and investment plan for community services (including a market analysis), set in the context of Local Area Agreements and Local Strategic Partnerships. As a result, they should have a clear prioritised service strategy, workforce and funding plan for community services, which will promote higher quality services, address unwarranted variations in quality and productivity, and avoid duplication. This should have been developed with the active involvement of practice-based commissioners.

- drawing on their market analyses, ensure that an appropriate range of community providers will be available to meet and sustain future patient care needs.

- satisfy themselves that their commissioning processes for community services have addressed the requirements of the Operating Frameworks 2007/08 & 2008/09, and the *Principles and Rules for Cooperation and Competition*, in ensuring sufficient separation of the commissioning and provision functions so that the right systems are in place to deliver World Class Commissioning effectively.

- provide a development programme for PCT provider staff, since leadership of a high calibre is critical to their success. This will equip them with relevant skills and competences to transform their services and compete confidently and competently in an environment of increasing patient choice, personalisation of services, and diversity of provision. They will also need to ensure that any future organisations providing PCT-commissioned services will also have the capacity to meet such development needs for staff.

- consider the implications for governance arrangements in both PCT Boards and provider sub committees and the management of conflicts of interest.

- consider with all the stakeholders, both the immediate and longer-term future of directly provided community services, in the context of greater competition, seeking and listening to the views of citizens, patients, staff, trade unions, practice-based commissioners, current providers and local authorities.

- ensure that proposals for future provision enable patient choice (for example, for patients with long-term conditions) and foster sufficient competition to drive-up and sustain quality and value for money; this means that proposals must fit with a realistic overall strategy for the structure of supply.

- consider the implications of any proposals for their role as employers. This means ensuring that staff are engaged and consulted early, their interests are considered, decisions have regard to workforce planning, high standards of workforce practice are met, and that change is led effectively and inclusively, and managed well. Mechanisms should be in place to ensure effective workforce planning and that all providers play their share in offering student placements, so that work opportunities for new graduates can continue in any scenario.

- have a clear and realistic strategy for the future of the community estate, assessing the estate's fitness for purpose and linking in to their commissioning plans. This will mean exploring options to ensure that the estate is managed on an efficient and flexible basis to accommodate future changes in need and to create a fair playing field on which all forms of provider can participate equally. This can be accomplished by a variety of means depending on the needs and challenges of particular health economies and should involve consideration of strategic partnerships (which may be regional or sub-regional) to provide property management expertise and funding. These are discussed in more detail in Appendix 1.

- ensure that due diligence has been carried out for any new arrangements, so that they are fit for purpose. This would include assessing any new arrangements against the employment standards set out in Appendix 2.

- consider and keep under regular review, at least annually, the viability of all provider services, including those accredited as any willing providers, and attendant financial and/or service risks.

1.5 **SHA Directors and Managers** who, as the regional system managers, are responsible for supporting and overseeing the separation of PCT functions and that PCTs promote patient choice and fair competition. In doing so, they will need to:

- satisfy themselves that PCTs have a robust process for effecting the separation process which is consistent with achieving World Class Commissioning.

- satisfy themselves that PCTs have a robust process for the development of the provider market for community services and have considered the implications for in-house provider services in operating in an environment of increasing choice. PCT supply-side strategies must be compliant with the *Principles and Rules for Cooperation and Competition*, promoting choice and ensuring fair competition.

- ensure appropriate development and leadership programmes for PCT provider staff have been available to prepare business readiness for operating successfully in an external environment.

- establish arrangements for the rigour and comprehensiveness of their local process leading to the PCT Board's decision on future arrangements and that there is consistency across the SHA area and neighbouring SHA areas. As part of its assurance role for *all* options, SHAs will take a 'gateway' approach to proposals, and the SHA should refer back to a PCT any proposals which are considered to be inappropriate, and/or where the governance or rigour of processes is demonstrably weak. There are particular requirements to be met in respect of the establishment of social enterprises under the staff 'right to request' scheme and NHS FT status which will require SHA approval, as well as assurance. SHAs will also assure that PCT provided services (PCTPS) are 'business ready' for April 2009 and will need to satisfy themselves that appropriate governance arrangements are in place and are properly established.

- for those PCTs that chose to retain directly provided services, periodically review with their Boards the reasons for this and any significant risks associated with sustaining viable direct provision.

- Work with the trade unions through the regional Social Partnership Forum to ensure there is effective communication and strategic joint working.

1.6 **Providers of community services** that are currently directly managed by the PCT, who will need to:

- keep all their staff fully informed of PCTs' and the provider organisation's plans. This should be supported through a consultation process agreed with the trade unions.

- progress business readiness for separation of the provider function from commissioning whilst still under the auspices of the PCT, including establishing robust governance arrangements that support the separation of the provider function ensuring conflicts of interest are properly managed.

- examine and appraise options for organisational form(s) – including direct provision – that would suit local circumstances and enable business proposals to be made in response to commissioning intentions and requirements. This should include considering the viability of each potential model and attendant financial or service risks. This should be done service-by-service, recognising that different options may suit different services.

- seek views and expectations of staff and their trade unions representatives, and their interest in making a "right to request" for a social enterprise or a similar request for another organisational form appropriate to local circumstances.

- submit business plans to PCT Boards for consideration and approval as appropriate.

- consider and keep under regular review, at least annually, the viability of directly provided services and attendant financial or service risks.

2. Strategic Context

Quality as the organising principle for the NHS

2.1 *High Quality Care for All* sets a clear overall vision – to make quality the organising principle for the NHS. It defines quality as spanning three areas: patient safety, patient experience and the effectiveness of care. It is these three things taken together that will make a quality service. This will require transformational change – by clinicians and other front-line staff, by the organisations providing community services and by commissioners.

2.2 This is why we have placed quality and enabling transformational change in both clinical practice and services at the core of the Transforming Community Services programme. We have already begun to co-produce with the NHS a Quality Framework for community services. This is being expressly designed to reflect the particular circumstances and challenges of community services, where much of the care and treatment is provided in people's homes, and needs to be both of a consistently high standard and personalised. An equally high priority is enabling transformational clinical practice – disseminating best practice and investing in developing clinical and leadership skills.

2.3 But the organisations providing community services must also change. They must be fit for purpose, empowering and enabling staff to provide safe, effective, personalised care. This will, in turn, require them to demonstrate the capacity and capability for transformational service change. Enabling this is the aim of this document.

Transforming Community Services Programme

2.4 *Our vision for primary and community care*[7] made a public commitment to creating modern, responsive community services of a consistently high standard. The Transforming Community Services programme has been established to support the NHS to deliver this. The programme will provide leadership and direction, reaffirming the central importance of community staff and services to delivering the Department of Health's vision of integrated, personalised care outside of hospital, and a renewed commitment to investment in modernising these essential services.

2.5 Running through the programme is the theme of quality as the organising principle for the NHS. Central to this will be a focus on enabling staff to transform services and their own practice, and a new over-arching Quality Framework (with which the incentives in Commissioning for Higher Quality and Innovation (CQUIN)[8] and the new standard contract will be aligned). Quality improvement and service transformation need to be

[7] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008
[8] *Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework*, Department of Health, December 2008

underpinned by world class commissioning and provider organisations which are fit for purpose and enable frontline staff to provide the best possible care. The programme is split into two components with clinical and service improvement being underpinned by business improvement.

2.6 Figure 1 shows how the Quality Framework acts as link between the business improvement work streams and those for clinical improvement. The key work streams have been highlighted in the 2009/10 Operating Framework.

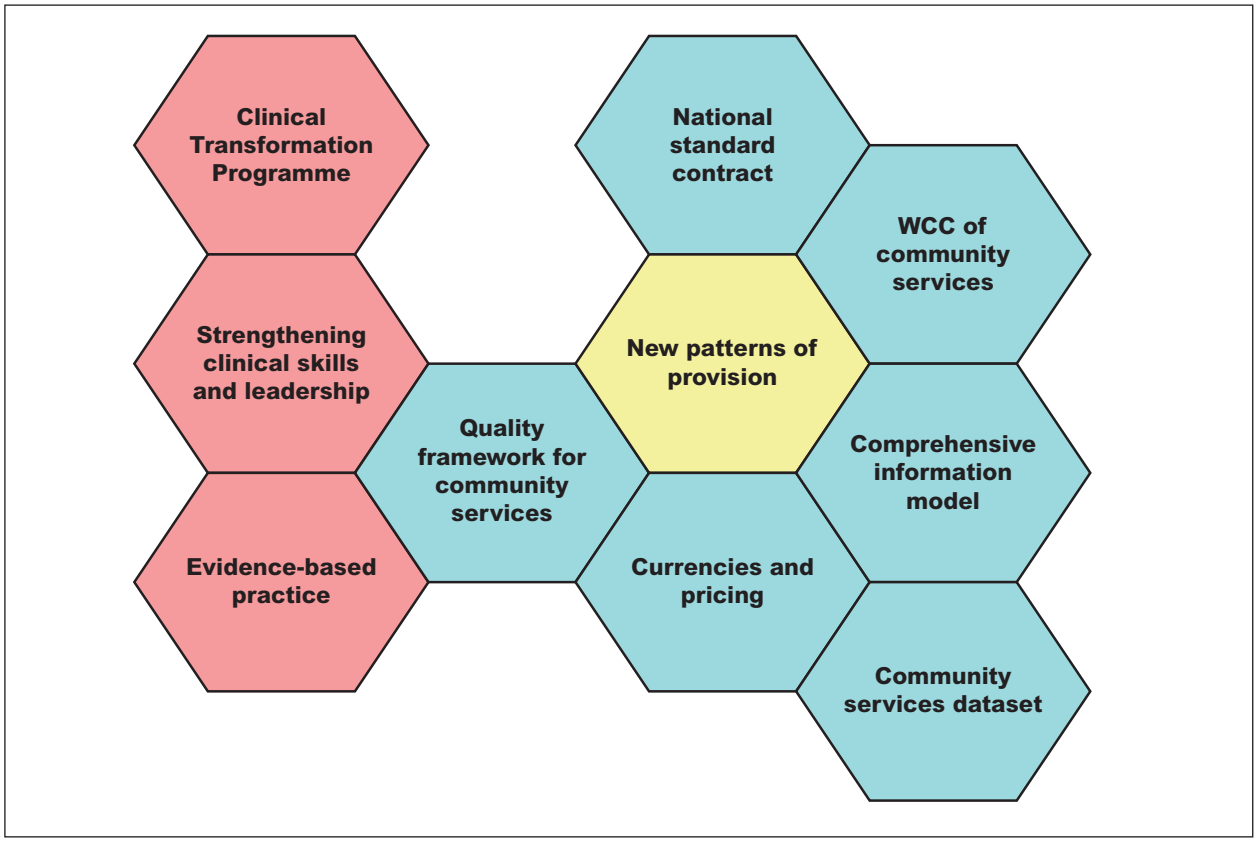

Figure 1: Business improvement workstreams and their link to clinical workstreams

World Class Commissioning

2.7 The World Class Commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world. World class commissioning is about delivering better health and well-being for the population, improving health outcomes and reducing health inequalities.

2.8 World Class Commissioning (WCC) will be one of the ways to deliver the NHS Next Stage Review and the Primary and Community Care Strategy. There is a clear vision to develop a patient-led NHS that uses resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare. Our health reforms are changing the way that health care is commissioned.

2.9 WCC is the primary vehicle through securing an improved range of modern, high quality, equitable community services, can be achieved. As it is required to operate within the new system reform environment of increasing choice and competition, this represents a particular challenge to those PCTs with direct, in-house community provision. Hence, the increasing necessity for PCTs to evidence clear separation of its commissioning from its providing functions so that it can commission and procure transparently and fairly, securing choice and value for money.

For further information on the commissioning of community services, see the Department's Resource Pack for Commissioners of Community Services.[9]

Choice and competition

2.10 The vision set out in the *Primary and Community Care Strategy*[10] is one in which people shape the services – people have more say, more choice and more control over their own health care.

2.11 Patient choice is firmly on the agenda for the NHS, and community services are key to the personalisation of care for people with long-term conditions, including mental health problems. Appropriate competition should give patients greater choice between providers of clinical services and models of care, and empower them to influence and shape the commissioning of healthcare services that they want and need.

2.12 Decisions about future options for the provision of community services must be taken within the context of, and be compliant with, the Department's published *Principles and Rules for Co-operation and Competition*.[11] In particular, PCTs will need to demonstrate how they will enable patient choice and ensure fair competition between providers. PCTs should be aware that the Cooperation and Competition Panel has now been established and will begin operating from January 2009 with the objective of ensuring that the NHS works within the *Principles and Rules for Cooperation and Competition*.

[9] Available at www.dh.gov.uk

[10] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

[11] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

Performance Regime

2.13 Extending the NHS performance regime to PCT direct provision will afford greater transparency and consistency in the performance management of both commissioners and providers of healthcare through identifying underperformance, supporting recovery and managing failure. The regime will set clear thresholds for intervention to address underperformance and a rules-based process for escalation, including defined timescales for demonstrating recovery. The regime will come into effect for PCT provided services in April 2009.

2.14 Where significant underperformance is not addressed through routine performance management, and attempts at recovery are unsuccessful, we will publicly designate organisations as 'Challenged'. 'Challenged' PCTs will be subject to intervention on behalf of the NHS Chief Executive, initially aimed at supporting recovery. Where a 'Challenged' PCT fails to demonstrate recovery within a reasonable timeframe the NHS Chief Executive will have the option of triggering a new transparent and rules-based regime for unsustainable providers. The objective of this regime will be to secure sustainable, high quality provision of services for the local community and to protect public assets (NHS land and buildings).

3. Guiding principles

3.1 Decisions about identifying and implementing future organisational options for the provision of community services should reflect the principles set out below.

Benefits for patients and carers

> **Patients' and carers' interests must be paramount** – this is especially important in the sphere of community services as so much of the care delivery is in highly personalised settings. Equality impact assessments must be undertaken on options as they develop.

> **Proposals must enable patient choice and personalisation** – for example, of provider, setting and treatment for people with long-term conditions.

> **Proposals must enable seamless care** – patients should experience joined-up services.

Needs of the population

> **Form should follow need** – a pre-requisite for PCTs is a clear commissioning strategy, with improving quality, value and reducing inequalities at its core.

> **The starting point should be the Joint Strategic Needs Assessment**, set out in the 5-year strategic commissioning plan. The form(s) in which services are provided should be the most appropriate to meet those needs rather than simply what meets business interests.

> **Providers should respond to needs** – providers will need to determine those organisational form(s) that best deliver high quality services rather than merely serve operational purposes. Different forms may suit different services, even within the same locality.

Staff

> **Staff employment rights and interests matter** – the workforce implications of any changes to the pattern of provision must be carefully considered and consulted on with the recognised trade unions. Any potential new providers must be able to meet agreed employment standards.

> **Staff and their trade unions should be engaged early and fully consulted on future arrangements** – they should be substantially involved in debating the issues and their views considered before any decisions are made.

> **Staff should have the 'first call' to offer to provide services under new organisational arrangements** – to build on existing clinical networks and offer stability to staff, existing

staff and management should be given the opportunity to propose either the creation of social enterprises through the 'right to request' scheme or NHS Community Foundation Trusts. Staff may also suggest other forms (see Chapter 7 for examples of these), and their views and those of their union representatives on these should be considered.

> **Workforce capacity is critical to delivering transformed community services.** Decisions on provider services should be supported by robust workforce strategies for building increased workforce capacity. All providers are expected to develop a 3-5 year workforce strategy a plan to address service priorities.

Local decision-making

> **Decisions about how services are provided must be locally led** – As the responsible statutory bodies, PCT Boards will decide, and make those decisions according to local needs. They will determine the pace at which new organisational forms will be adopted, and what those forms will be.

> **Assurance, approval and authorisation processes need to be clear and robust at every stage at both regional and local levels** – an open, transparent process, capable of being endorsed as such by the relevant governance body.

> **Wider stakeholder views are also important** – including those of patients and community representatives, LAs and OSCs, – these should be considered in shaping future arrangements.

World Class Commissioning

> **Proposals must enable World Class Commissioning** – proposals should free up PCTs to focus their energies on becoming world class commissioners, with their provider services at arms length and working in a contractual relationship.

Competition

> **PCTs should also encourage – where necessary – entry by other appropriate potential providers** – the PCT's procurement strategy needs to ensure a sufficient range of providers to enable patient choice and drive up quality and value for money. Organisational options should fit with the PCT's' broader market strategies, which consider the choice and competition implications of any set of provider options.

> **PCTs should give support to prospective providers, including staff who request to set up a robust social enterprise** – the PCT should provide whatever support is appropriate, proportionate to the business, in order that prospective providers can be business ready to enter the market.

> **Proposals must comply with the Department's published *Principles and Rules for Cooperation and Competition.***

Collaboration

> **Form should be robust and reflect function** – PCTs should look beyond their immediate boundaries and work collaboratively with others to consider the possible reconfiguration of services across more than one PCT, if appropriate.

> **PCTs should work in partnership with local authorities** – to deliver a coherent community strategy as laid out in *Putting People First*,[12] to which the NHS is cosignatory.

> **Proposals should enable joined-up health and social care service provision or other LA services such as with Housing, Education and Leisure.**

Continuity and preservation of assets

> **Service continuity must be secured** – any risks that continuity might be affected need to be mitigated through the failure regime.

> **Assets and value, especially estate, must be protected – and should not normally transfer to providers.** Providers will be tenants, not owners of estate and the duration of their tenancies will be linked to commissioners' contracts for services. This does not necessarily mean that commissioners need to retain day-to-day management of the estate. PCTs should consider how strategic partnerships (discussed later) could assist in managing the estate more efficiently and flexibly, providing better value.

Options for new organisational forms

> **There is a range of potential options for providing community services** – from PCT directly-provided services (which will continue to be an option where well-managed and more business-like), to Community Foundation Trusts, social enterprises, integration with other NHS organisations, partnerships with Local Authority services, and PCTs contracting with practice-based commissioners, integrated care organisations, or non-NHS bodies. Different forms may suit different services and hybrid organisations derived from more standard original models may well emerge.

> **There is no prescribed ideal form.**

> **Regardless of organisational form, there will be core basic expectations of organisational competence.**

[12] *Putting People First – the whole story*, Department of Health, October 2008

4. What PCTs need to do

Involving clinical leaders, staff and stakeholders

4.1 In the process of achieving separation of the commissioning and provider functions, and throughout the journey towards new patterns of provision, PCTs, as Commissioners and providers, should involve their main stakeholders as early and as fully as possible:

> **Clinical staff** are key to enabling the vision set out in the *Primary and Community Care Strategy*[13], in driving improvements to quality, access and health outcomes and in supporting integration of care across organisational boundaries.

> **Practice-based commissioning** is the primary route for involving clinicians in commissioning. As such, practice-based commissioners have a key role to play as commissioners and providers in shaping the development of community services, and must be fully engaged.

> **the whole workforce** is a key part of any organisation and to any service reconfiguration. The importance of maintaining good communication is key to ensuring that workforce implications are carefully considered and included in any planning.

> **users of NHS services** must be involved, not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered. NHS bodies must comply with their duty under section 242(1B) of the NHS Act 2006, and have regard to the related guidance given under section 242(1G) of the Act.

> **partners must be engaged**, including local authorities, the Third Sector and other current providers.

4.2 For further information on involving stakeholders, see Appendix 3.

Engaging staff and considering their interests

4.3 Skilled, empowered, motivated staff are key to the delivery of safe, effective, personalised services. Their employment rights, training and development and interests matter. The current and future workforce implications of any changes to the pattern of provision, therefore, must be carefully considered and consulted on. This means that staff and their union representatives should be engaged early and fully consulted on future arrangements – they should be substantially involved in debating the issues.

[13] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

4.4 The importance of maintaining good communication and working effectively with trade union representatives cannot be underestimated. It is often the "softer" HR aspects such as effective communication, effective listening and timely engagement that provide for a positive outcome or otherwise. Often there is an underestimation at the start of the process about the time and effort that maintaining good communications might take. However, if handled well, many longer-term benefits can arise. Conversely, if workforce issues are not well handled then difficulties that could arise will take more time and effort to resolve. Good communication is key to ensuring that workforce implications are carefully considered and included in any planning. This also applies regionally. The SPF for each SHA will have a responsibility for supporting change management and ensuring that best practice is followed. In addition to consultation at PCT provider-level, SHAs should share and discuss PCT plans with trade unions at SPF-level.

4.5 Staff should have the 'first call' to offer to provide services under new organisational arrangements – to build on existing clinical networks and offer stability to staff, existing staff and management should be given the opportunity to propose either the creation of social enterprises through the 'right to request' scheme or NHS Community Foundation Trusts.

4.6 It is essential that PCTs meet high standards of workforce practice throughout the change process. Appendix 2 sets out in some detail the key issues relating to staff, which the managers and boards of PCTs should consider. These include:

> **Consultation**: PCTs should draw up a plan for consultation with staff and their trade union representatives, to be shared with the SHA. The plan should include early consultation with staff and their representatives in the initial consideration; and subsequent appraisal and development of proposals for the future delivery of services provided by PCT provider arms;

> **Protection of pay terms and conditions and pensions** – Appendix 2 addresses this issue in some detail;

> **Ensuring equality**: No employees should receive less favourable treatment on the grounds of age, gender, marital status, race, religion, creed, sexual orientation, colour, disability, working patterns or trade union membership. It is important to understand the potential impact on equality of any change. Employers should undertake an equality impact assessment to evaluate the impact of change;

> **Enabling training and continuing professional development**: Continued investment in training, pre-registration clinical education and placements and CPD is essential to support staff in providing quality services and enabling them to transform their individual practice. PCT Boards when considering proposals for future organisational options should seek assurances about approaches to CPD and assess any implications for, for example, training rotations and that SIFT SLAs are robust.

> **Participation in workforce planning**: PCT Boards should seek to demonstrate how, in future, they will secure access to a HR function assurances that there will be continued participation in workforce planning, including the staff census. Providers would be expected to develop 3-5 year workforce strategies and robust plans which outline their strategic vision and priorities for their workforce and cover plans for recruitment and retention;

> **Standards of workforce practice**: New organisations, or existing PCT provided services, will be expected to adopt agreed standards of good practice in respect of matters such as grievance, disciplinary, flexible working, and dignity at work policies. Such expectations would need to be proportionate for smaller organisations.

> **Values**: All organisations providing NHS-funded community services will be expected to observe the NHS Constitution and the values set out in it.

4.7 The process of moving from separation of the PCT commissioning and provider functions to other possible organisational models is illustrated below in Figure 2.

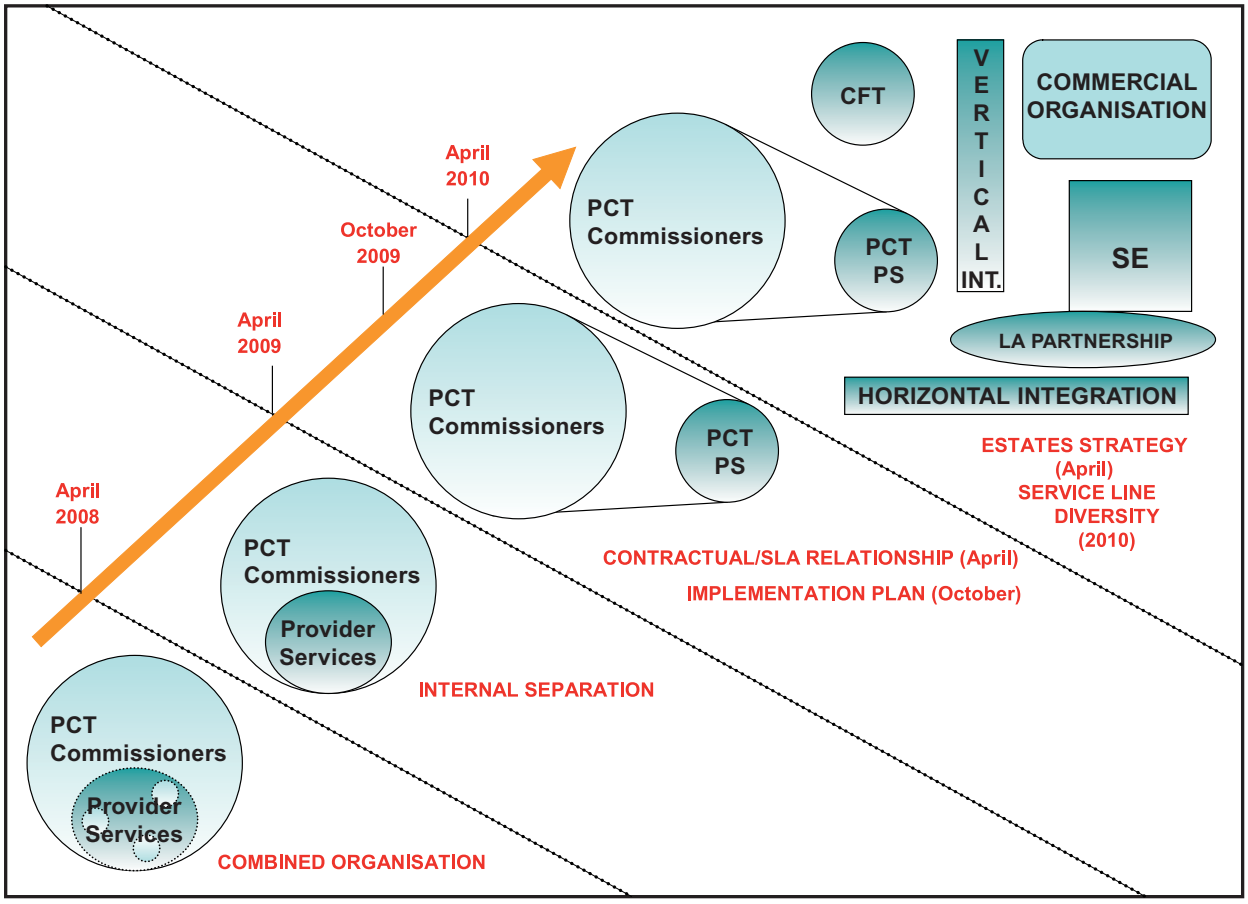

Figure 2: Changes in patterns of provision

Timetable

4.8 Many PCTs have already made significant progress in the process of separation, and others will be at earlier stages. As stated in the Operating Framework 2009/10:[14]

"PCTs should ensure that their operational provider services are fit for purpose and able to perform effectively alongside all other providers. By April 2009, provider services should be in a contractual relationship with their PCT, providing sufficient separation from commissioning roles to avoid potential conflicts of interest."

4.9 AS A MINIMUM, therefore:

by April 2009

> all PCT direct provider organisations must have moved into a contractual relationship with the PCT commissioning function, and be business ready, using in 2009/10 the National Standard NHS Contract for Community Services and/or Mental Health Services.

Where a PCT cannot demonstrate by April that it has made substantial progress against the Department's Business Readiness for PCT provision guidance,[15] it should draw up a development plan, agreed with the SHA, to ensure sufficient business readiness by October 2009.

4.10 PCTs seeking a best practice model for further service development would, it is anticipated, have the following in place:

from April 2009

> PCTs should be developing and sharing commissioning strategies for community services that will inform development of organisational options.

by October 2009

> PCTs (as commissioners) and practice-based commissioners, should jointly have developed a detailed plan for transforming community services, priorities for improvement and service development, and what they propose to do to enhance patient choice and introduce sufficient competition to drive up service quality and value for money.

> PCT provided services, in the context of their commissioning strategy, will have reviewed the options for most appropriate organisational forms that best suit local need and circumstances and considered whether or not to declare an interest in establishing a social enterprise or Community Foundation Trust for any services – see Appendices 6 and 7 for the processes involved. This review will have to take place in good time to influence the PCT's commissioning plan.

[14] *Operating Framework for the NHS in England 2009/10*, Department of Health, December 2008 (para. 47, p.30)

[15] *Business Readiness for PCT Provision,* Department of Health – an executive summary will be published on www.dh.gov.uk.

from October 2009

> PCT commissioning arms, engaging practice-based commissioners, should complete service reviews and a market analysis, and establish and publish a procurement plan in line with the intentions in its 5-year Strategic Commissioning Plan.

> PCTs will provide to, and agree with, their SHAs their intentions for the future of provider services, timescales for potentially establishing social enterprises or Community Foundation Trusts, market testing and a plan for supply-side development or integration with other NHS organisations (see chapter 7 for examples).

no later than April 2010

PCTs will have agreed with their SHAs a clear and realistic strategy for the future of the community estate that will ensure that the estate's fitness for purpose is assessed in the light of current and future commissioning intentions, exploring options to ensure that the estate is managed on an efficient and flexible basis to accommodate future changes in need.

during 2010

> During 2010, and following agreement PCTs should develop their implementation plan. SHAs will be responsible for ensuring that PCTs make substantial progress in implementing their plans, paying attention to the requirements of particular options.

4.11 If, at any time, PCT staff have declared an interest in establishing a social enterprise, either in respect for the whole or part of the current provider organisation, that request should have been considered and approved or rejected within 6 months of the request being made. Staff trade union representatives should be informed of, and be able to influence, all options being considered by PCTs in advance of any decisions being made.

4.12 Where a PCT decides to maintain direct provision, it should periodically review its service quality, viability and any financial risks or risk to sustainable services. The SHA will assure that this process is robust.

5. Commissioning high quality community services

5.1 A pre-requisite for considering future options for the provision of community services is a clear commissioning strategy, with improving quality, value and reducing inequalities at its core. The World Class Commissioning framework describes the requirements and the set of core competencies. Underpinned by the needs-based 5-year Strategic Commissioning Plan, PCT commissioners, will complete service reviews, using tools such as SHAPE (the Strategic Health Asset Planning & Evaluation tool), and a market analysis, then establish and publish a procurement plan.

5.2 A resource pack for commissioners of community services[16] was published in January 2009. Linked to other key documents in the Transforming Community Services Programme, in particular the national contracting and pricing framework, the high-level data set, the information model and the development of a quality framework, it sets out good practice in commissioning community services. It also highlights current examples, demonstrates innovation in service development through case studies, and signposts relevant information.

5.3 Stimulating the market presents a particular challenge. The diagram below illustrates this process within World Class Commissioning, highlighting the specific step of shaping the structure of supply.

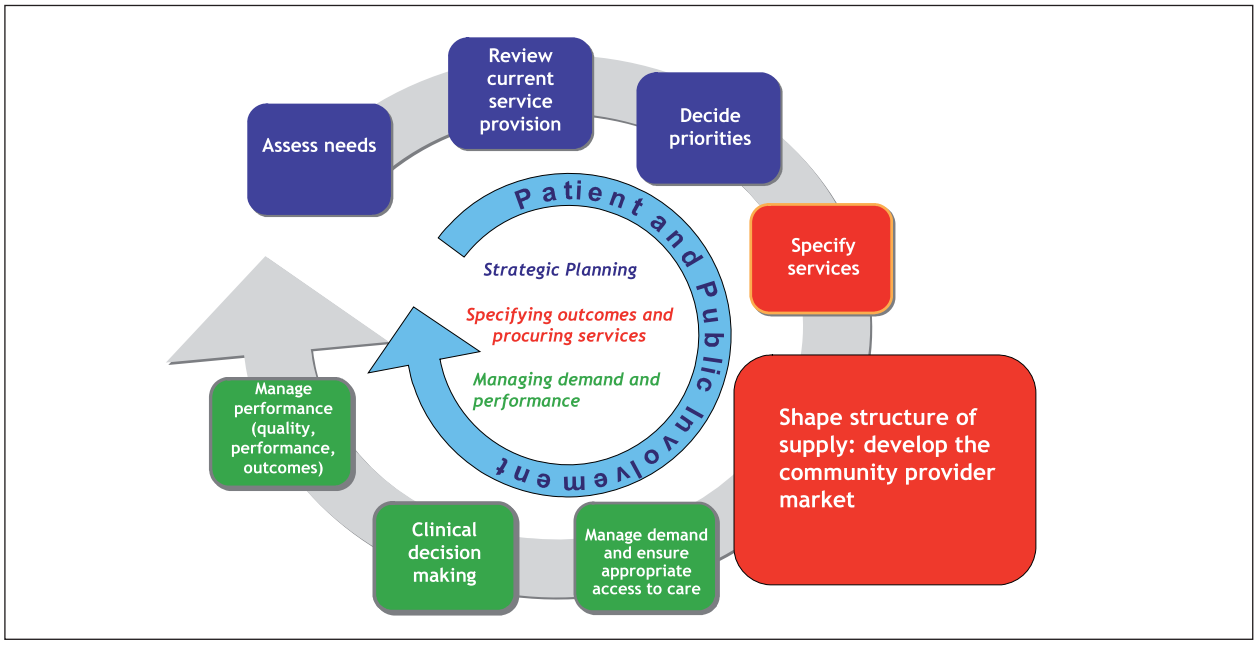

Figure 3: World Class Commissioning: the context for shaping the structure of supply

[16] *Good Practice Resource Pack for Commissioners of Community Services*, Department of Health, January 2009

Any Willing PCT-accredited Provider (AWPP)

5.4 Commissioners should, as part of their approach to commissioning community services, set out an indication of which services may be subject to seeking 'any willing PCT-accredited provider' (AWPP) status or competitive tendering, and over what timescale. This is important in helping to ensure that provider business planning is based on realistic assumptions about the future direction for services.

5.5 The AWPP model is a variant of the basic any willing provider (AWP) model which is described in the current PCT Procurement Guide.[17] It retains the core features of the AWP model, namely open access for providers of defined services who:

> are registered with the Care Quality Commission to provide the defined service

> agree to comply with appropriate standard NHS contract terms

> are paid at national tariff or some other agreed local common rate for the services

> and who get no guaranteed volumes of activity.

Like any other provider, an accredited provider under these arrangements will be expected to meet good workforce standards.

5.6 Where it differs from the AWP model is in the right for Commissioners to specify additional, service specific "accreditation" requirements, such as specific standards or access requirements, to meet specific local service and patient needs, which, might not be covered in sufficient detail in the essential requirements for safety and quality that need to be met in order to be registered with the Care Quality Commission.

5.7 It is expected that AWPP would be used where there is a well-defined service area or pathway, which is capable of being provided by a number of providers, and which has well developed payment regimes. Given that there would be no activity volumes committed to providers, it is likely that services with high set up or fixed costs would not be as suitable for AWPP.

Further guidance on the AWPP model will be provided when the national PCT Procurement Guide is updated in the Spring of 2009.

[17] *PCT Procurement Guide for Health Services*, Department of Health, May 2008

A stepped approach for commissioners

5.8 Figure 4 summarises the key steps in the commissioning and procurement of community services. The steps are firmly the responsibility of the commissioner who must evidence fairness and transparency; providers should not be active participants in this part of the process. Taking this approach will prevent conflicts of interest. This approach also applies to other services that align with community services, notably acute secondary care.

5.9 In establishing their vision for the optimum provider landscape, PCTs are unlikely to achieve the separation of commissioning and provider functions, and opening the provider market up to new entrants in one short exercise. Nor might the vision be complete in the first instance. Nevertheless, the steps they propose to take to achieve these aims should be reflected in their competition strategy.

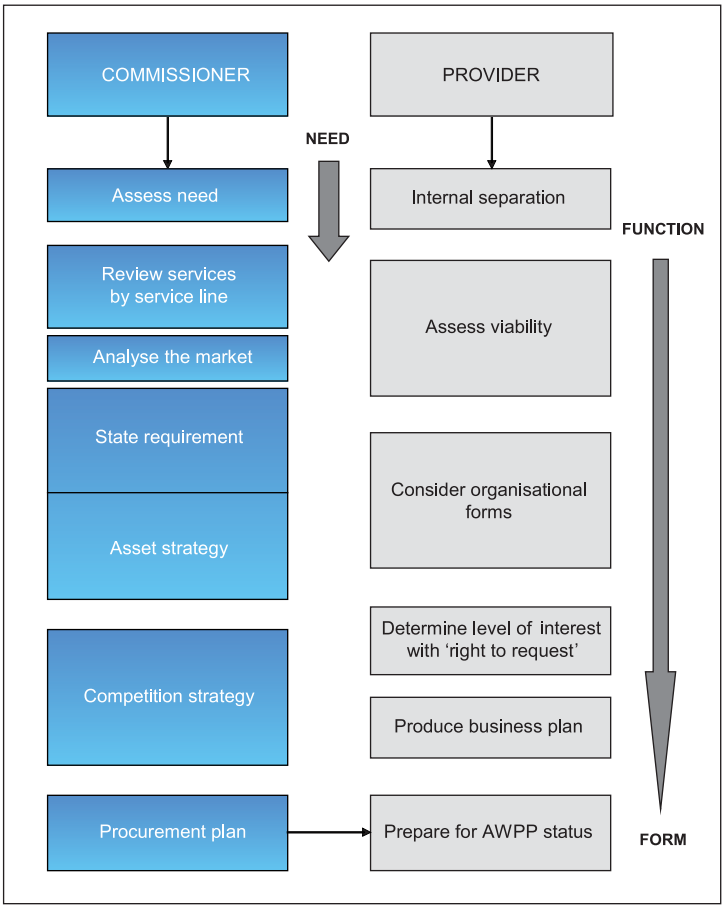

Figure 4: The stepped approach for commissioners

5.10 When considering potential supply-side strategies, *there is a wide range of possible organisational forms with which PCTs can contract with for the provision of community services*. Some of these are illustrated in Chapter 7, grouped around some core types of ownership models (the examples given are not exclusive):

> NHS organisations

> Foundation trusts

> Social enterprises

> Commercial enterprises

> Contractual, partnership and joint working arrangements

Contracts for community services can also be placed with:

> Integrated Care Pilots (where these are established)

> Primary care providers

5.11 It is very likely that the chosen solution (or solutions) will vary, as they will be based on the local health economy needs. Examining options service line by service line, PCTs may need to explore and implement a range of solutions to maximise efficiency of their service configurations and thereby deliver optimum benefits for patients.

5.12 Chapter 7 provides supporting information on key issues such as legal forms, tax, and governance.

5.13 In drawing up their supply-side strategy, PCTs will need to find the right solution for service areas that are unlikely to be attractive to external providers – for example, whether to retain them in the PCTPS, or arrange for their provision on a sub-regional or regional level. The supply-side strategy will also have to balance the need to sustain viable, high-quality suppliers, whilst promoting choice and innovation through encouraging new entrants. In particular, the PCT will need to be clear about any shifts towards vertical or horizontal integration, which result in a reduction in competition or choice. The development of existing provider organisations should not in the medium-term concentrate the provision of services in a more limited number of organisations.

Assets

5.14 When developing a supply-side strategy, commissioners need to think carefully about how buildings and other infrastructure should be held and managed. Assets, especially estate, must be protected and should not normally transfer to providers. This is so that commissioners' leverage is maximised and that providers collaborate effectively to ensure viability and value for money. For example, commissioners may wish to place providers on fixed term contracts to improve competition and quality by periodic market testing. The effectiveness of this mechanism is blunted however if the available infrastructure is mostly controlled by a small number of provider organisations because:

> a commissioner's ability to negotiate service improvements or reconfigurations is limited; and

> concentration of key sites, assets and high cost equipment in the hands of a small number of providers could act as a barrier to new market entrants.

5.15 These concerns are true, whether or not the services in question are preferential or open to competition. In either case, a commissioner must have the ability to engineer change and improvements. Separation of provision from the asset base is an essential component of this. As a minimum, commissioners should ensure they have an up to date inventory of their accommodation and that tenancies with providers are placed on proper commercial property leases coterminous with service contracts.

5.16 Retention of estate should not be seen by commissioners as an indirect route to enforce a predetermined configuration of providers on the healthcare system. Rather, it is the means by which a fair playing field will be created for an appropriate blend of providers to become established. That is to say, appropriate in the context of each local health economy.

5.17 Where a provider who owns their own property does comes into the market, the PCT will need assurance that the property is fit for purpose. But as a general rule, commissioners should plan on the basis that – for community services – they will normally take responsibility for the provision of the infrastructure from which providers, as tenants, will operate. This is consistent with the requirement for providers to operate on the same basis and financial rules, irrespective of the origin of the provider.

5.18 Appendix 1 sets out the role of infrastructure in helping PCTs transform community services, and explains the differences between alternative forms of estate provision. It also sets out how strategic partnerships can assist in managing the estate more efficiently and flexibly, providing better value, and explains in brief the rules and regulations applicable to the management of estate.

6. Providing high quality community services

6.1 A move away from direct provision of community services offers NHS staff exciting opportunities to use their talents, enthusiasm and skills to take more control in delivering services responsive to the needs of the communities and people they serve. Through innovation and redesigning services in flexible new ways in independent organisations such as social enterprises, clinical leaders and others can exert their influence to improve outcomes like never before.

6.2 Providers of community services, whether existing or prospective, need to be in a position to offer innovative and dynamic proposals to the commissioner requirements. They need to do this in the environment that encourages choice and competition. Local clinicians are ideally placed to make such responses, but need to be so organised as to demonstrate viability and sustainability if they are to be successful in securing contracts.

6.3 The *Primary and Community Care Strategy*[18] encourages community staff to consider levels of independence and produce proposals through a right to request to reform themselves into entities that can be recognised in the market place. Such right to request extends to social enterprise and other forms.

6.4 There is clearly a timeline for which developments of this kind need to form and mature, and therefore a clear plan leading to implementation and shadow working is desirable.

6.5 So that provision, particularly as in-house moves to different form(s), can be credible participants, the notion of 'accredited any willing provider' is likely to become more and more appropriate.

6.6 In response to the commissioner stating the requirement for services, the provider will need to go through a process, illustrated in the diagram below, of:

> internal separation

> in the light of the PCT's commissioning strategy, assessing the viability of service lines

> considering appropriate form(s) for provision

> identifying and declaring any interest in developing a social enterprise or NHSCFT and follow the application processes (see Appendix 4 for the right to request a social enterprise process and Appendix 5 for details of the CFT process)

[18] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

> if there is no interest in pursuing a social enterprise or NHSCFT application for all or part of the current services, assess the viability of those services and put forward proposals to the PCT board for their future management. This could be to continue as a direct provider organisation (with strengthened business management) which is capable of being accredited to become an 'any willing provider' of services, or a process of managed divestment (most likely through a Part B procurement – see the *PCT Procurement Guide* for further information on what this entails).

> the PCT board will need to form a view as to whether the provider's proposals represent a viable proposition which will enable service transformation, sustain services and manage financial risk acceptably. In the light of the PCT's response, produce a business plan appropriate to the options being pursued.

> except in the case of managed divestment, prepare to become an accredited 'any willing provider' to the PCT for an identified service(s).

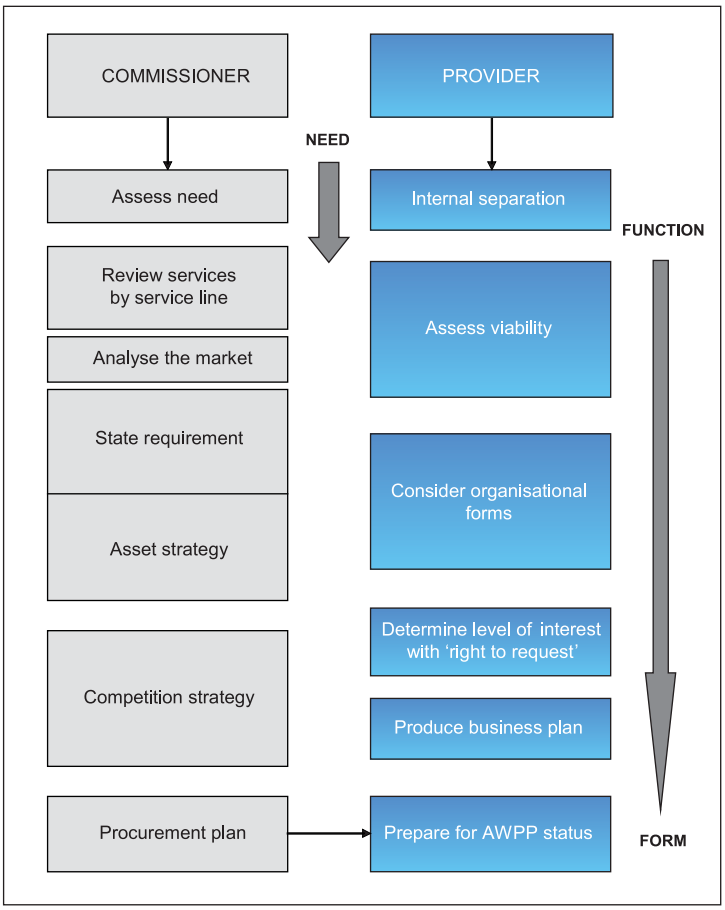

Figure 5: The stepped approach for providers

Preparing the ground: achieving internal separation

6.7 The first step in the internal process is to effect separation. The Operating Framework for 2008/09 set PCTs a task, to 'create an internal separation of their operational provider services, agree SLAs, based on the same business and financial rules as applied to all other providers'.

6.8 PCTs do not necessarily have to divest themselves from the provision of local community services, but those that continue to provide services must ensure there is clear arms length separation with their provider services and that they are fit for purpose. This is essential to ensure that all community providers on a fair and equal footing and subject to the same competition rules. As a minimum, PCTs provider organisations must be capable of working in a rigorous, transparent contractual relationship with its commissioner.

6.9 The business readiness guidance, the executive summary of which will be published on www.dh.gov.uk, provides a detailed list of principles that SHAs and PCTs should consider. In order to avoid conflicts of interest, it is good practice to draw up a Memorandum of Understanding, underpinned by scheme of delegation of authority. These will support an agreement outlining the delegated accountability between the PCT Chief Executive and the Director of Provider Services.

6.10 The Provider sub committee has internally delegated responsibility for the provision of services, the functions legally remaining the responsibility of the PCT Board. They must continue to have oversight of those functions and the assets liabilities of the provider arm remain assets and liabilities of the PCT, The Provider Committee will need to have robust, detailed information in order to run its organisation economically, efficiently and effectively. As good practice, it should put in place the mechanisms required to fulfil this duty, for example managing its budget on service level data.

6.11 The Provider sub committee should provide both excellent management and clinical leadership and independent scrutiny and challenge. Membership will typically consist of a Chief Operating Officer/CE Designate; lead Executive for Finance; and appropriate high level clinical leaders and several Non-Executive Directors to offer oversight and challenge.

6.12 A separate process of audit should be in place either by setting up a separate audit committee or by ensuring that agenda items on the main PCT Audit Committee are kept separate.

6.13 Further guidance will be published in early 2009 on the operation of PCT provider committees, such as the role of non-executive directors, and other governance issues. DH are working with the Appointments Commission on this guidance.

Assessing viability

6.14 The Provider Organisation must know its business to determine how to progress. It needs to understand its environment and drivers for services, its external and internal challenges so that it can identify its risks and then put plans in place to mitigate those risks.

6.15 To assess its viability, the provider organisation must also know how it can sustain itself in the long term; it must understand the commissioner's strategic intentions and have a detailed command of its portfolio of contracts and associated risks. Commissioners should be in continuing dialogue with providers about ongoing service reviews and analyses of need.

6.16 As the National Standard NHS Contract for Community Services and/or Mental Health services will be available, provider organisations should be working towards having an informed and transparent contracting relationship with its commissioners. It will need to provide quantitative and qualitative information defined locally using the mandated service specification template within the national standard contracts. The community metrics, high level data set, information models and pricing and currency framework will help both Commissioners and Providers start the move from block contracting to commissioning for outcomes.

6.17 When the provider is satisfied that it knows its business, understands the intentions of its commissioners, has consulted with all its stakeholders, it should produce a detailed business plan.

Considering appropriate organisational form(s)

6.18 There is a range of possible organisational forms for PCT providers to consider. Chapter 7 provides information on some forms, but the list is not exhaustive.

6.19 The organisational forms for PCT provider arms to consider will be driven by a number of factors, such as the extent to which:

> staff wish to be involved in an organisation as stakeholders as well as employees

> other local stakeholders such as patients and partners such as local authorities wish to be involved in the organisation

> there are implications for current partnership arrangements with LAs or the potential for future such arrangements. Advice on technical issues relating to partnership arrangements will be made available through Q&As on www.dh.gov.uk.

- the expected future operation of the organisation will require assets to be held in a separate legal entity
- the organisation is capable of accessing commercial or other funding sources
- it is important that the organisation has charitable status
- there is a strong local community identity that needs to be represented in the organisation.

6.20 If a joint structure with a third party is being considered, then it is likely that party will have its own commercial governance and policy considerations, which will also have to be taken into account.

6.21 Some of the options listed in Chapter 7, and in particular options which involve the creation of a corporate joint venture, would require not just PCT Board Approval, but also SHA and DH approval. If assets are to be transferred then this might also require separate PCT Board and SHA approval.

6.22 The Department's view is that it would be inappropriate to create new NHS Trusts for community services, as this would run contrary to current policy for the development of NHS Foundation Trusts. The only exception would be as the intermediary stage necessary to the process of moving to CFT status.

6.23 Where a provider wishes to remain in the NHS, but is assessed as non-viable as an independent organisation, it could consider merger or a host management arrangement with another NHS organisation or service.

6.24 The process of applying for CFT status is set out in Appendix 5.

6.25 Children's Trusts have been omitted as an organisational form. These are in part, planning bodies which inform commissioning decisions and ensure (through a range of sometimes agency specific approaches) that front line services work together to improve outcomes. Revised statutory guidance[19] was issued in November 2008 that reflects the Children's Plan commitment to strengthening Children's Trusts. DCSF anticipate bringing forward legislation to empower and encourage local partners which may include establishing a statutory basis for Children's Trust Boards and strengthening the statutory framework for Children and Young Peoples Plans.

[19] *Children's Trusts: Statutory guidance on inter-agency cooperation to improve well-being of children, young people and their families*, DCSF, November 2008

6.26 Information on how to exercise the right to request is set out for staff in *Social Enterprise – Making a Difference*.[20] A summary of the process is at Appendix 4.

6.27 Appendix 2 provides information on the implications for staff of different organisational forms.

Determining the level of interest on exercising a 'right to request'

6.28 A 'right to request' may come from various sources, from a small group of clinicians, to large numbers of staff across a variety of organisations or even a whole PCT provider service. To embark on this, the collective interested in this should read the Department's guide *Social Enterprise – Making a Difference: a guide to the Right to Request*.[21]

6.29 For whatever type of pattern of provision staff choose, they need to identify the benefits, the vision, values and mission before embarking on its business plan.

Producing a business plan

6.30 We recommend as good practice the Department of Health's and Monitor's Guidance on how to develop an integrated business plan. Although this is used for NHSFT applicants, it can be used for any group or organisation developing its business plan. The guidance includes:

> the work already completed on the viability and profile of the organisation

> its vision and mission

> its market assessment including its PESTLE analyses

> service development plans including its SWOT analysis and future initiatives

> financial plans including detailed five year projections

> risks

> workforce arrangements

> governance arrangements

[20] Department of Health, November 2008

[21] Department of Health, November 2008. See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090460

Preparing for accreditation to 'any willing PCT-accredited provider'

6.31 PCTs as commissioners will accredit willing providers under the same principles as for any other procurement and in line with their PCT's commissioning and procurement strategies. In procuring services from willing providers, the PCT will want the same assurance of competence, quality and safety standards as it would for services secured under a formal tender process.

6.32 Providers will be required by the PCT to demonstrate competency against a range of possible core, service specific and other criteria that the PCT will set. These are likely to include:

> engagement of staff in the design and provision of services

> clinical leadership

> management competency and capacity

> legal and governance models

> contractual arrangements

> partnership working with staff

> compliance with the requirements of the Cabinet Office Code and NHS Constitution and Handbook.

6.33 Providers preparing for accreditation to a PCT will also need to demonstrate that they can meet a range of key criteria such as:

> providing patient-centred, responsive services

> offering value for money

> offering good access to services

> delivering high quality services

> meeting high human resource management standards

7. Organisational Forms

7.1 In considering new organisational forms, there is a range of key factors that will need to be considered.

Management capability and capacity

7.2 Both Executive and Non-executive management capability and capacity will be key to the success of the new organisation. PCTs will need to consider the following competencies for the four key areas of the organisation – Individual Board Members, The Board as a whole, Leaders and Senior Managers, and the Wider Organisation:

> Vision and Strategy

> Business Skills

> Commercial and business awareness

> Robust finance

> Robust governance, accountability and responsibilities

> Sustainable and enabling relationships

> Clarity and Challenge

> Change and Transition

> Behaviours

Legal form

7.3 The legal form of the provider will determine who owns and runs the organisation, its governing documents and whether it is regulated by any body. In brief:

> when the functions of the PCT commissioner and provider services are separated, the legal structure of the PCT remains the same. Legally, the services are provided directly by the PCT.

- where there is vertical integration with another NHS provider organisation such as an acute trust or mental health trust, the provider services will not be fully autonomous, as they will be part of a wider provider organisation. Hosting arrangements for the provision of services will vary, (such as a separate business unit or full integration along a care pathway) depending on the nature of the integration.

- Any board governing the provider services will be a sub committee of the main board of the overall organisation, operating under a scheme of delegation. The Chief Executive of the overall organisation will remain the accountable officer for all services.

- One option outside the NHS but still within the public sector would be for a PCT provider service to be integrated into the relevant local authority. This is often referred to as horizontal integration and provides for the integrated provision of health and social care. There is sufficient legislation to allow local authorities to take on PCT provider service functions[22].

- the legal type of a social enterprise will depend on the particular form. There are many forms of social enterprise, including community interest companies, charities and industrial and provident societies. Information on the legal form and governance of each of these is available in the chart which follows.

Staff

7.4 While evaluating the options for organisational form, PCTs need to take into account any impact on the retention of staff of the form selected. Some forms may lend themselves better than others to factors that are important to the staff e.g. pensions and professional training and development opportunities. Therefore, staff and their union representatives need to be engaged and consulted at key stages to ensure that their views and any concerns are taken into account.

7.5 Regardless of which form of provider organisation is chosen, the staff transferring to the new organisation will be its most valuable asset, having been trained and qualified for the services. In the short term, availability of such staff is likely to act as a barrier to entry for other new providers and hence in effect likely to ensure effectively exclusive access to the market. Therefore, the value of the goodwill transferred needs to be recognised in any relationship between the PCT commissioners and the providers. The PCT will also need to consider any opportunities to share any potential productivity gains with the provider in the medium to longer term.

[22] such as section 75 of the NHS Act 2006

Tax and VAT

7.6 Some organisational models are subject to different tax arrangements. Independent sector providers will pay corporation tax on their income from NHS-funded patients, and will not be able to reclaim VAT to the same extent as NHS Trusts. This could potentially affect the price at which these organisational models are able to provide services, however it is equally likely that large independent sector providers are able to achieve an efficiency of scale that enables them to reduce costs in other ways.

7.7 If PCTs choose to form an organisation that is outside the NHS other than an LA[23], they will not be able to recover VAT on cost inputs to providing healthcare. The provider's prices would therefore have to recover these costs in the price of services to the PCT. In considering whether VAT is chargeable on services under different arrangements, it is advisable to consider two tests:

> The nature of supply to see whether it is VAT able, exempt or zero rated

> Determine whether the activities are supporting statutory obligations of providing NHS healthcare or whether it is a business activity (applicable to NHS bodies only).

7.8 If staff are seconded from an NHS organisation to a body set up outside the NHS, the cost is likely to be subject to VAT. Hence the individual will cost 15% (new rate for 13 months from 1 December 2008, then will revert to 17.5%) more than the cost of in-house provision.

7.9 If new types of bodies are set up within the NHS, the agreement of HM Revenue and Customs will be required for them to be included in the NHS divisional VAT registration.

7.10 HM Revenue and Customs will need the details of any new NHS bodies (whether of a new type or not) to ensure they are included in the divisional registration.

7.11 The *Transactions Manual*[24] provides information on the VAT implications for certain organisational forms, but financial advice should be sought in the context of each individual organisational form.

Transfer of liabilities

7.12 The *Transactions Manual* includes detail on the current rules, policy and best practice advice when transferring assets and liabilities. The accounting treatment in various envisaged circumstances is set out in the Manual at chapter 21. Parties should also rely on their financial advisors when entering into a transaction.

[23] See http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Healthact1999partnershiparrangements/index.htm
[24] Due for publication in early 2009 – see www.dh.gov.uk

7.13 Arrangements made by virtue of section 75 of the NHS Act 2006 do not affect the liability of NHS bodies for the exercise of any of their functions.

Transfer of business

7.14 Where a business is transferred to another party through a process of divestment or acquisition the *Transactions Manual* provides guidance in terms of law, policy and best practice to guide organisations, on both sides, through the process.

7.15 If the process by which business is transferred is by commissioning activity of an alternative Provider rather than a corporate transaction, the *Transactions Manual* has no function. Parties should be aware that liabilities, particularly around staff (TUPE), may still transfer in these circumstances and should seek appropriate legal and financial advice.

Process of divestment

7.16 The *Transactions Manual*[25] includes a chapter specifically on divestments that helps organisations through the divestment process. If a divestment is undertaken the Manual should be followed.

7.17 Some of the key features of each type of business model are set out below.

[25] see www.dh.gov.uk

NHS organisations

Example	Description	Separate Legal Entity	Legal Route	Governance
Direct Provision	1. Provision of services remains with the PCT but with separate governance arrangements so that the provider service is treated like any other provider. 2. An alternate approach would be for the PCT to agree with another PCT either to manage or to deliver their directly provided services: under a delegation arrangement the relevant functions are delegated to the other PCT. A PCT can also commission services from another PCT; this could involve existing staff transferring to the provider PCT.	No, PCT continues to be the legal entity provided the service and the provider arm remains part of the PCT.	The PCT needs to put appropriate governance and financial arrangements in place to ensure no conflict of interest. Regulation 10 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements Regulations 2003 (SI 2003/2375) enables a PCT to: (a) delegate provider functions to a committee or employees of the Trust; and (b) enter arrangements under which the provider functions are delegated to another PCT or a joint committee. Section 21(2) of the NHS Act 2006 enables a PCT to provide community services for another PCT under a commissioning arrangement.'	The services continue to be provided by the PCT in exercise of its statutory functions. The PCT board remain ultimately accountable for this activity. The PCT may however want to delegate the governance of the provider arm.

Example	Description	Separate Legal Entity	Legal Route	Governance
Community Foundation Trust	A Public Benefit Corporation consisting of members who may be in constituencies of the public, patients and staff. There is a Board or Council of Governors and a Board of Directors.	Yes. An FT is a corporate body known as a public benefit corporation (s.30 of NHS Act 2006).	An NHS Trust may apply for authorisation as an FT (section 33 of the 2006 Act). Other persons or bodies may apply to be incorporated as a public benefit corporation and authorisation as an FT (section 34). Applications considered and authorisation given by Monitor (s.35). For a PCT provider arm an NHS trust is created to take on the provider arm and apply for FT status under s.33.	FT is governed by its board of directors. Board is partly accountable to, and appointed by, board of governors. Board of governors are elected by the members' constituencies. FT reports to and is regulated by Monitor.

Social Enterprises

Social enterprises are businesses that trade primarily for social purposes, with profits reinvested into services it provides or into the wider community. There are several legal organisational forms, including, amongst others, a Community Interest Company, a Company Limited by Guarantee, and an Industrial and Provident Society.

Example	Description	Separate Legal Entity	Legal Route	Governance
Company Limited by Guarantee	Usually non-profit distributing, often combined with charitable status. Members play a role similar to that of shareholders. Profits are retained within the company to be applied in accord with its purpose.	Yes.	Registering a company is simple with standard forms of Memorandum and Articles of Association available (although checking with a legal expert to ensure they are appropriate is advisable). An application to incorporate as a company is submitted to Companies House and processed within seven working days at relatively low cost (details can be found at www.companieshouse.gov.uk).	The governing document is the "Memorandum and articles of association", usually abbreviated to "mem and arts". It is governed by "the directors" or "the board of directors", although the mem and arts may use some other term to describe the directors. For example, if the company is also a charity, the directors may well be described as "trustees" (charity trustees being the generic term in charity law for members of the governing body).

Example	Description	Separate Legal Entity	Legal Route	Governance
Industrial and Provident Community Benefit Society (BenCom)	BenComs are incorporated industrial and provident societies (IPS) that conduct business for the benefit of their community. Profits are not distributed amongst members, or external shareholders, but returned to the community.	Yes.	To register as a BenCom, you must demonstrate your social objectives and your reasons for registering as a society, rather than a company. It can cost between £40 and £950 to register a BenCom with the FSA – payable each year. The fee depends on the BenCom's assets and whether it registers under self-written rules or FSA-approved rules.	The governing document is "The Registered Rules". The management/ governance is essentially two-tier, with a committee of management accountable to a wider structure membership (sometimes referred to as a "participating membership"). Members will typically hold voting rights at general meetings and will elect all or some of the committee. However, it is possible to create a single-tier structure by simply stating that the society shall be managed by general meetings. All IPSs are required to have a secretary, this person may also be a member or director, but need not be. In funded community and voluntary organisations, the post of secretary will often form part of the job description of a member of staff.

Example	Description	Separate Legal Entity	Legal Route	Governance
Industrial and Provident Societies (Bona Fide Co-operative)	In a bona fide co-operative, eligibility for membership will be based on sharing a common economic relationship with the society – employees in a worker co-operative, tenants in a housing co-operative, etc. The eligibility criteria will feature within the registered rules.	Yes.	Societies are registered with the Mutual Registration division of the Financial Services Authority (FSA) rather than Companies House. Only societies that meet the social criteria defined in the Industrial and Provident Societies Act 2002 can be registered and the Financial Services Authority (FSA) has a significant regulatory function in relation to registration. The FSA has the power to suspend or ultimately cancel registration if a society does not adhere to its registered purpose.	The governing document is "The Registered Rules". The management/ governance is essentially two-tier, with a committee of management accountable to a wider structure membership (sometimes referred to as a "participating membership"). Members will typically hold voting rights at general meetings and will elect all or some of the committee. However, it is possible to create a single-tier structure by simply stating that the society shall be managed by general meetings. All IPSs are required to have a secretary, this person may also be a member or director, but need not be. In funded community and voluntary organisations, the post of secretary will often form part of the job description of a member of staff.

Example	Description	Separate Legal Entity	Legal Route	Governance
Community Interest Company (CIC)	Designed for the pursuit of community benefits, CICs can be either limited by guarantee or limited by shares and are additionally required to satisfy a 'community interest test'.	Yes.	A CIC is registered at Companies House. However, there is one additional form to complete containing a statement that the CIC is pursuing the community interest and a declaration that the company is not excluded. Companies House passes the application to the CIC Regulator who assesses whether the 'community interest test' has been passed. It is then returned to Companies House.	The governing document is the "Memorandum and articles of association", usually abbreviated to "mem and arts". It is governed by "the directors" or "the board of directors", the same arrangement as for a limited company, although the mem and arts may use some other term to describe the directors. A CIC must first be registered as a limited structure company. Becoming a CIC is an additional status overlaid on the basic company structure.

Example	Description	Separate Legal Entity	Legal Route	Governance
Charitable Incor-porated Organisation (CIO)	This form becomes available by regulation in 2009. It is a separate legal entity with a constitution consisting of members who may have no liability or liability limited to a maximum amount.	Yes.	The introduction of the CIO removes the requirement for organisations requiring incorporation and charitable status to have dual registration with both Companies House and the Charity Commission. The CIO will be singly registered with the Charity Commission.	The governing body Is referred to in the Act as the "trustees", the generic term in charity law for members of the governing body. The management/Governance is unknown as yet, but it is proposed that there will be the possibility to have either a two-tier system, with a board of trustees accountable to a wider membership (sometimes referred to as a "participating membership"); or a single-tier structure whereby only the trustees may be members and vice-versa, although these two roles will still exist within the company, the same people will perform both.

Commercial Enterprises

These are not shown as although these forms may be contracted with by PCTs to provide community services, they are not available for PCT provider organisations to establish directly.

Contractual, partnership and joint working arrangements

In addition to direct contracts with PCTs by independent organisations to provide community services, there are also some possible arrangements between the same or different types of organisation, and do not, therefore, constitute organisations in themselves. Below are some models of how services might be arranged.

Example	Description	Separate Legal Entity	Legal Route
Vertical Integration	These can be arrangements between NHS organisations and other bodies, whether other NHS organisations (eg NHS trusts, NHS Foundation Trusts), or local authorities or third sector organisations, typically, carrying out different stages of a patient or user pathway. These can be carried out through a contractual Joint Venture, a Community Interest Company, partnerships, or a Section 75 Agreement.[26] There is no prescribed form for vertical integration. Proposals for vertical integration must be compliant with the requirements of the *Principles and Rules for Cooperation and Competition*.[27]	Depends on nature of integration. It can involve the transfer of services to another corporate body or other legal entity, or a contractual agreement to deliver different parts of a service together. Choice of legal route will be determined by a wide range of factors including whether the arrangement is intended to be permanent, or simply for the duration of a particular contract.	Depends on form, extent and permanence of integration. NB. Primary Care Trusts are unable to form or participate in the formation of companies, other than LIFT companies or as part of an income generation scheme.

26 ref

27 ref

Example	Description	Separate Legal Entity	Legal Route
Horizontal Integration between PCT providers and/ or LAs	PCTs enter joint arrangements or services are transferred to ("hosted by") another PCT. PCTs and LAs enter section 75 partnership arrangements whereby the LA performs the PCT's community health services function. Typically such arrangements are developed between providers delivering the same part of a patient pathway or service. Proposals for horizontal integration must be compliant with the requirements of the *Principles and Rules for Cooperation and Competition*.	No new legal entity is established, but the services may be provided by an entity (LA or PCT) separate from the original PCT. Joint arrangements with another PCT or LA may not involve a separate entity, but can be simply agreements.	With LAs = partnership arrangements under s.75 of the Act and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. With other PCTs = regulations under 2006 Act (see regulation 10 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements Regulations 2003 (SI 2003/2375)) enable a PCT to exercise functions jointly with another PCT, or delegate functions to another PCT. Or PCT could transfer staff/property to PCT and commission services from that other PCT. Where an arrangement involves the delegation of a function to another PCT in accordance with regulations under the NHS Act 2006, the other PCT becomes responsible for the delegated functions, although the delegating PCT board remains responsible for monitoring the arrangements (see paragraph 16 of Schedule 5 to the NHS Act 2006). But under a section 75 partnership arrangement, where PCT functions are delegated to a local authority, the local authority performs the functions on behalf of the PCT and the PCT and its board remain responsible for those functions (see section 75(2)(b) and (5) of the NHS Act 2006).

Example	Description	Separate Legal Entity	Legal Route
Partnership arrangements under s.75 of the NHS Act 2006	Under these arrangements a local authority provides the relevant former PCT community health services.	See above	As per the legislation – see s.75 of the NHS Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (see above). Where an arrangement involves the delegation of a function to another PCT in accordance with regulations under the NHS Act 2006, the other PCT becomes responsible for the delegated functions, although the delegating PCT board remains responsible for monitoring the arrangements (see paragraph 16 of Schedule 5 to the NHS Act 2006). But under a section 75 partnership arrangement, where PCT functions are delegated to a local authority, the local authority performs the functions on behalf of the PCT and the PCT and its board remain responsible for those functions (see section 75(2)(b) and (5) of the NHS Act 2006).

Example	Description	Separate Legal Entity	Legal Route
Services provided on behalf of a PCT by a third party	Options for these include joint or delegation arrangements with another PCT (see 'horizontal integration' above). For external bodies other than another PCT, the PCT cannot delegate functions to such a body.	No. Should always be documented, with a written agreement which spells out which services are being delivered.	Usually contractual. For joint/delegation arrangements with another PCT see 'horizontal integration' above.
Integrated Care Pilot (ICP)	An entity that takes overall responsibility for ensuring coordinated care for a defined and registered (GP) population wherever that care is to be provided i.e., across part or the whole patient pathway, irrespective of sector. These are being piloted following the NSR.	Depends on the underlying business model of the ICO Pilot, but may well require a degree of organisational and operational separation.	Will be contractually supported by whatever organisational model is chosen by the ICP.
Primary Care Contracts	May still be used for the purposes they were originally intended.	Legal form contract.	As per legal contracts.

Example	Description	Separate Legal Entity	Legal Route
NHS Contracted Arrangement	An existing hospital Foundation Trust managing some community services (Downwards). Primary and community care organisations managing some acute services from community base (Upwards).		

Note: the National Standard NHS Contract for Community Services and/or Mental Health Services applies to all providers of community services.

8. Implementation

8.1 Once clear separation between the PCT commissioning and provider functions has been achieved, a detailed implementation plan will need to be developed, in discussion with the SHA and in consultation with the trade unions, signed off by it, and approved by the PCT Board. The plan should incorporate clear governance arrangements for the period of transition and should cover:

- commissioning activity leading to the competition strategy and procurement plan for community service providers;
- staff, union, and stakeholder engagement plan and communications strategy
- provider separation arrangements
- identification of organisational models and their appraisal leading to preferred selection
- development of robust business plans for preferred model(s) and their evaluation for appropriateness, viability and sustainability
- service and business continuity plans for the period of development
- development and training plan for skills and competencies to assist providers make successful transition to new forms
- risk assessment, mitigation and management plan (this should cover finance, service and workforce issues)
- a timeline with key milestones identified.

Key Responsibilities

8.2 The corporate PCT Board is responsible for ensuring that the plan is robust in its accountabilities, pays appropriate attention to staff involvement facilitating their 'right to request' if made with due consideration of submitted business cases, formal consultation with their employees and their trade unions when relevant, and having a decision-making process for the eventual determination of future arrangements.

8.3 Of equal importance is the development of senior executives/managers and clinicians whose remit is dominantly the direct provision of community services (see paragraph 5.11). Like world class commissioning there is a similar need for a set of competencies necessary to lead, manage and deliver in the new environment of the contested marketplace. With the opening up of the choice of different organisational forms and the emergence of social enterprise new skills need to be acquired. It is reasonable to expect that PCTs and SHAs will provide development programmes and resources sufficient to equip clinical and managerial staff with skills they need.

8.4 To address all these requirements there are specific roles and responsibilities for PCTs, especially Non-executive Directors, SHAs and the Independent Advisor for Social Enterprises. These are described below.

The Role of Non-Executive Directors during the Transition Phase

8.5 With the evolving requirements of world class commissioning to secure the highest quality for best value for local people, the contested market place and the in-house community services provider within that environment, the potential for conflict of interest heightens if not in actual fact but by external perception. That said, the responsibility remains for a substantial number of direct employees and the services they deliver. Consequently, there is an over-riding need to ensure that adequate and appropriate preparation, development and support is undertaken to achieve an acceptable level of competence to compete well in the new environment.

8.6 From a commissioning perspective, Non-Executive Directors will need to satisfy themselves that service specifications and procurement processes are sufficiently robust to avoid the risk of leaving some services fragmented or vulnerable.

8.7 The PCT would need to establish the Provider Committee as a formal Sub committee of the main PCT Board. Such a Committee would need to have the delegated authority to make decisions in line with the PCTs Standing Orders and Standing Financial Instructions and A Scheme of Delegation. The means by which they discharge their dual responsibilities might be through a Memorandum of Understanding. This would allow specified NEDs to focus and carry out functions specific to a provider type organisation with transparency to the main PCT Board(s) and in recognition of access to information may give rise to potential conflict of interest. The timeframe might also be specified to indicate the transition period. In order for this to work, the PCT Board should ensure it has the full quota of NEDs.

8.8 More guidance on the role of NEDs and other governance issues will be published shortly.

The Role of Strategic Health Authorities

8.9 SHAs have an essential role and responsibility to quality assure the process adopted by PCTs to determine the most appropriate outcome for their local circumstances.

8.10 The business readiness guidance, the executive summary of which will be published at www.dh.gov.uk, sets out how SHAs can assist PCTs to separate their commissioning and providing functions. It is for the individual PCT Board to decide on the degree of separation, externalisation and choice of organisational form but this is only after having taken due regard of the SHA's considered views. If needs be there should be an iterative process between the PCT and SHA who can refer back proposals to a PCT for revision or further consideration.

8.11 As part of its assurance role for *all* options, the SHA should refer back to a PCT any proposals which are considered to be inappropriate, and/or where the governance or rigour of processes is demonstrably weak. There are particular requirements to be met in respect of the establishment of social enterprises under the staff 'right to request' scheme and NHS FT status that will require SHA approval, as well as assurance.

8.12 In summary, SHA activity will be to:

> oversee and assure the decision-making process of PCTs

> provide support and guidance to PCTs

> take an active role to ensure that any conflict of interest for PCTs does not influence decisions on organisational forms

> ensure good communications through the regional Social Partnership Forum

> develop a cohesive development plan for the exchange on knowledge and learning at Chair/NED and Executive level

> facilitate co-operation between neighbouring PCTs on possible joint provider options

> discuss and agree with PCTs an implementation plan and for those who have not achieved separation by April 2009, a development plan to ensure sufficient business readiness by October 2009

> sign off the PCT's estate strategy by April 2010

> approve applications for SE or NHS CFT status

> review all arrangements at least annually

> continue the development of commissioning and procurement of community services.

8.13 SHAs will also assure that PCT provider services are substantially 'business ready' and have developed leadership skills for April 2009.

8.14 The SHA, as system manager, could also test proposals with or seek the view of the National Competition Panel if it is unsure or concerned about any implications for fair competition.

8.15 The SHA also has an important part to play in the development of providers to be both capable and competent in the contested marketplace. As in previous arrangements with the formation of Foundation Trusts it is expected that the SHA will undertake development programmes designed to raise competency levels both in clinical leadership and business skills.

8.16 The SHA has a crucial role to play in engaging with its regional Social Partnership Forum. The SPF for each SHA will have a responsibility for supporting change management and ensuring that best practice is followed. In addition to consultation at PCT provider-level, SHAs should share and discuss PCT plans with trade unions at SPF-level.

Regulation

Arrangements until April 2009

8.17 Health and adult social care regulation is currently carried out by the Healthcare Commission (in relation to healthcare), the Commission for Social Care Inspection (in relation to adult social care) and the Mental Health Act Commission (in relation to the Mental Health Act). The Care Standards Act 2000 sets out the providers which private and voluntary healthcare providers and adult social care providers have to register with the Healthcare Commission and the CSCI, and the regulations that these providers must comply with. The NHS, although monitored by the Healthcare Commission, does not have to register.

Arrangements for regulation 2009-2010

8.18 The Care Quality Commission will take over from the Commission for Social Care Inspection, the Healthcare Commission, and the Mental Health Act Commission on 1 April 2009 as the independent regulator of health and adult social care. During this first year, private and voluntary healthcare providers and adult social care providers will continue to be regulated under the Care Standards Act 2000, and the Care Quality Commission will take over the functions of the Healthcare Commission and CSCI in this respect. From the 1 April 2009 it will also be necessary for NHS providers to register with the Care Quality Commission, as set out in the Health and Social Care Act 2008. This will include PCT directly provided services. Regulations made under this Act will set out the requirements for registration. The response to the consultation is available at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_092312 on controlling the risks posed by infections.

8.19 It is important to note that any new private or voluntary healthcare providers (which includes social enterprise), arising as new models of community care from PCTs, will need to register with the Care Quality Commission, under the Care Standards Act.

Arrangements for regulation from April 2010

8.20 From April 2010, all providers of regulated health and adult social care services will need to register with the Care Quality Commission, as set out in the Health and Social Care Act 2008. The provisions under the Care Standards Act 2000 will cease to apply to these providers, and regulations made under the 2008 Act will set out which providers will need to register and what the registration requirements will be. The system will be coherent across all regulated providers, independent of whether they are NHS, private or voluntary healthcare, or adult social care. Only providers of regulated activities will be required to register and the list of activities will be developed based on risk, which could mean that only a proportion of services currently provided by PCTs would be required to register.

9. Making decisions on the new arrangements

9.1 This section will describe the responsibilities of key players in the system who need to contribute to the decision-making process. It brings together the tasks outlined in earlier chapters.

Who decides

9.2 The PCT has the statutory responsibility for securing the provision of community services to its local population, and is also the direct employer of the existing community healthcare workforce and owner of the related assets. In coming to its decision the Board must satisfy itself that due and proper processes have been followed, consultation with staff, trade unions and involving OSCs and other relevant bodies has been conducted in line with best practice guidance, and that account has been taken of risks.

Who assures the process

9.3 The SHA has a fundamental role in quality assuring the processes undertaken by the PCT leading up to making its decisions. The SHA, in discharging its responsibilities, should satisfy itself that the outcome:

> meets the needs of the population

> delivers high quality community services for local people

> is properly integrated within the broader health and social care economy

> facilitates the development of a plural market

> has been equality impact assessed and is, and remains, viable.

Who approves the decisions

9.4 The approval process for moving to particular organisational forms will vary, as different forms have different requirements and regulators. For example, the decision that a CFT model is the most suitable for local circumstances would require Monitor to establish whether the formal application to become a CFT met its criteria for approval. Prior to this,

we would expect the SHA to have approved or rejected applications. SHAs will ultimately approve the establishment of 'right to request' social enterprises. The decision for a vertical integration would require the agreement of the boards of the parties who made up the partnership in question. As part of its assurance role for *all* options, the SHA should refer back to a PCT any proposals which are considered to be inappropriate, and/or where the governance or rigour of processes is demonstrably weak. In the event of the SHA having evidenced concerns over the adequacy of the process and the PCT Board being confident in its decision, then referral to the Competition Panel for independent consideration of the positions of each party could be made to aid resolution.

Who monitors and evaluates the outcomes

9.5 Throughout the processes to determine appropriate outcomes, attention should have been focused on the benefits realisation expected over a given period of time. This will be of interest, not just to the PCT as a Commissioner, but also to key interest groups, notably LINks and health Overview and Scrutiny Committees. It is therefore expected that, post creation of new arrangements, including a decision to maintain a direct provider organisation, there would be at least an annual review of performance against intended benefits.

Appendix 1 – Capital, Estates and Infrastructure

Infrastructure

A.1 "Infrastructure" in this context relates to the physical resources necessary to deliver primary healthcare. This may consist of combinations of:

> land and buildings of varying levels of complexity funded by public capital, the freehold for which is owned by the PCT;

> property held on a Lease under standard commercial arrangements;

> fully serviced accommodation leased under a Local Improvement Finance Trust (LIFT);

> accommodation provided under the Private Finance Initiative (PFI);

> IT assets and ICT services; and

> other equipment, either owned or leased.

When and how should we think about Infrastructure?

A.2 Figures 4 and 5 set out the steps a PCT, as commissioner or provider, should follow to transform community services. This annex considers what each process step means for a health economy's physical infrastructure.

A.3 Prior to conducting an assessment of its estate, a commissioner needs to understand what the healthcare needs are for its local health economy. Need should always be the fundamental driver of estates provision. There are five key steps:

> At the outset a commissioner needs to complete its **Needs Assessment**.

> to **Review Current Service Provision**, a commissioner must ask what is the current configuration of health estate? Where are assets located, what services are delivered from them and how are assets held (eg owned or leased)?

> having **Decided Priorities**, and compared commissioning intentions with current available infrastructure, what does the resulting gap analysis suggest regarding the location and suitability of the estate and equipment?

> having specified services, what does this mean for the future development of estate, the options at the commissioner's disposal and the range of delivery mechanisms available to ensure the closest possible fit between **Service Specification** and estates provision?

> how should a PCT assemble a migration plan to effect separation of functions and a seamless transfer of assets and services? Any plan should take into account the degree of flexibility and resilience required as a buffer against changing service needs.

What drives the need for infrastructure?

A.4 Before considering the type of infrastructure required, who should own it and how it should be managed, we must first answer four basic questions:

> ***what*** do we want to do?

> ***where and how*** do we want to do it?

> ***who*** do we want to do it?

> ***when and for how long*** do we want to do it?

The first question is answered by the PCT's own assessment of the state of its health economy contained within the Joint Strategic Needs Assessment.

Review of current service provision: what preparation work does a PCT need to undertake?

A.5 In order to compare itself with the standards that comprise World Class Commissioning, the PCT must assemble a snapshot of its current operations, the estate from which it is delivered and the equipment housed within it. The starting point for this analysis will be the PCT's asset register, but the PCT will also need to understand fully which assets it owns outright, and in the case of land and buildings what, if any, restrictions apply to their usage. For example:

> buildings may be restricted to healthcare use and

> buildings and/or equipment may have been gifted or have other restrictions attached to charitable donations used to purchase them,

which may affect a PCT's ability to dispose of them or alter the way in which they are used. It is also necessary to understand which assets are leased and what the terms of those leases are.

What should an analysis of current configuration look like?

A.6 The PCT needs to assemble a snapshot of its asset base that is from the legal, property[28] and financial perspectives. This is essential to:

- ***determine what the book value of total assets and liabilities held by the PCT is.*** This provides the starting point from which the balance sheets of the commissioner and providers can be built and forms the basis for the value of any intra-NHS asset transfers or loans;[29]
- ***highlight any constraints on the transfer or disposal of particular PCT owned sites*** in advance of any analysis of their fitness for purpose as healthcare premises;
- ***highlight any breakage costs or other operational constraints associated with leased property*** eg limitation of the PCT's ability to refit or remodel leased premises;
- ***set out the PCTs obligations as both tenant and (in certain circumstances) as landlord*** which new organisations may have to assume; and
- ***provide the starting point for any value for money assessment.*** Transformation cannot be undertaken simply for its own sake; it must demonstrate that the combined costs of assets and services prior to transformation exceed operational costs post-reconfiguration, allowing for improvements in quality and efficiency.
- ***identify any legal commitments/obligations that may affect the options available to PCT.*** For example, where a PCT has entered into a LIFT arrangement, it will have granted LIFTCo the exclusive right to provide future healthcare facilities in a defined area and above a specified value (subject to certain conditions, such as LIFTCo's proposals demonstrating value for money). This may affect a PCT's ability to establish a new structure and/or contractual relationship to deliver its future estate requirements. Other contractual arrangements may also need to be taken into account in considering the infrastructure models (eg, current facilities management (FM) arrangements or agreements with other healthcare bodies/local authorities).
- ***determine the condition of each element of the estate.*** This provides the starting point for any investment plan and should embrace the quality of accommodation in terms of meeting current design and technical standards, environmental sustainability, flexibility, and suitability for emerging pathways of care.

[28] see para A.9 for use of the SHAPE toolkit

[29] Asset transfers to any non-NHS bodies are at open market value rather than book value. There is also a requirement for overage in disposals to non NHS bodies

A.7 The commissioner will have formed an understanding of need and available infrastructure. The combination of the two forms the basis for a gap analysis from which priority infrastructure investment, disposal or remodelling can be identified to deliver priority needs.

What should a gap analysis cover in infrastructure terms?

A.8 This analysis should consider the range of services to be delivered and how they should be configured. It should also consider whether current estate is suitable given:

- anticipated changes in the location of services;
- changes in the types of services to be delivered (for example, through the transfer of acute activity into a community setting);
- changes in the way in which certain services are to be delivered (for example, providing care in a home rather than hospital or clinic setting);
- access standards, such as maximum travel times from certain forms of provision;
- what level of future investment is required in terms of value and timing;
- consideration of effectiveness and efficiency of the assets.

A.9 Any analysis of location, demography and activity is greatly assisted by the use of Strategic Health Asset Planning & Evaluation (SHAPE)[30]. SHAPE is a web enabled, evidence based application, which links clinical analysis and demographic data with healthcare estates performance and facilities location, in order to inform and support the strategic planning of services and physical assets across a whole health economy. SHAPE is configured to SHA and PCT boundaries and seeks to facilitate scenario planning and option appraisal.

A.10 Developed by the Department of Health, the application can assist service reconfiguration and the improved integration of health and social care services informing the vital dialogue with stakeholders through four interlinked components – Clinical Analysis, Estates analysis, GIS mapping and Demography. The clinical activity fields in SHAPE provide an analysis of Health Episode Statistics (HES) data including high and low volume activity, uncoded activity, multiple readmissions and average lengths of stay. The datasets also include Key Performance Indicators (KPIs) relating to the Trust and PCT owned estate. All data is linked to GIS (Geographical Information Systems) mapping which also incorporates demographic data and travel time analysis.

[30] see http://www.dh.gov.uk/en/Managingyourorganisation/Estatesandfacilitiesmanagement/DH_080774

What is the output of the gap analysis?

A.11 This analysis provides a map of need. When overlaid with the PCT's assessment of its current configuration, it illustrates the service gap that the PCT must bridge. The map should highlight:

- the differences in complexity of estate according to which services need to be provided from it;
- which estate is fit for purpose in terms of functionality and location;
- which estate is in the right location but requires remodelling or refurbishment to deliver the right volume of services of appropriate quality;
- which estate is surplus to requirements;
- what constraints exist, property, financial or legal, to refurbish, remodel or dispose of existing estate and property; and
- where new investment may be required.

A.12 The gap analysis sets the PCT a number of challenges which must be addressed through its estate management strategy. This estate strategy will be delivered by the commissioner, as the organisation responsible for establishing the level playing field within which providers will be expected to operate. Part of this responsibility involves shaping estate to fit commissioning.

Specifying Services

A.13 In specifying services, a commissioner is setting out what it wishes to be delivered, how and from where. Some of these services will be deliverable from existing estate; some from improved estate; others from new locations and infrastructure. The estate is never static, but instead should be capable of flexing with commissioners' changing needs.

A.14 This section considers the powers and limitations within which commissioners should manage their estate, as well as the options available for its management. These options range from direct, in-house management to more ambitious forms of strategic partnership with the private sector.

Overview of Options

A.15 The ability to hold and operate estate effectively depends on a number of factors including strategic asset management capability, the ability to access capital and the expertise not only to maintain buildings and equipment, but to remodel the estate through capital works or sale and redevelopment.

A.16 Whilst many NHS primary care organisations have access to capital, it may not necessarily be sufficient to fund large-scale developments. Not all NHS organisations have access to the in-house expertise to develop estates strategies or deliver a basic operational service, nor will they necessarily have the ability to undertake the property development work necessary to release value from the existing estate in order that it can be fed back into future developments.

A.17 Ownership of property should be driven by the service delivery options, which should detail the required expectations for buildings and facilities. Much depends on whether the service is viewed as a short, medium or long-term requirement. In addition, service continuity and flexibility should be an important factor in the decision making process. For example, a portfolio of leases of varying terms could well provide the flexibility required in the shorter or medium term. Alternatively, where a core service is seen as a long term requirement or a contentious use is required, freehold ownership could provide a more cost effective solution. All forms of ownership have their advantages and disadvantages. Proper, professional advice should always be sought.

A.18 The commissioner's approach to risk determines the acceptability of holding its own property versus conventional leasing or a LIFT or Strategic Estates Development (SED) model. If the commissioner opts to hold its own estate, then it may be exposed to all of the risks as well as rewards of property ownership. The risks are mostly constant, as property continually deteriorates; the rewards are intermittent and arise when property is sold. Many organisations opt to transfer property and its attendant risks to external partners with access to the skills and supply chain to manage them better. There are a number of different ways to do this.

Management Contracts

A.19 Access to the required skills can be obtained by contracting with specialist advisers to do those things a PCT cannot do for itself, though the PCT will need to have the expertise to act as an informed client in order to purchase these skills. The day to day management of estate can be passed to a service provider through a management, or other form of service, contract. This form of provision may be suitable for larger organisations with some estates expertise to monitor a contract effectively and with a relatively static asset base, adequate funding, where little property development expertise is required.

Strategic Partnerships

A.20 There is currently considerable interest in initiatives which can enable PCTs to pass the day to day management of properties to strategic partners. One such partnership, LIFT, already exists. A number of PCTs are considering the potential for whole estate solutions, either with or without LIFT. The thinking behind these Strategic Estates Development (SED) models is at an early stage and there are a number of key legal and commercial issues that the Department is working with pilot sites to solve. Both LIFT and SED are discussed in more detail below.

A.21 The key to making strategic partnerships work is making sure that there is a proper linkage between what commissioners want and how this is translated into estates requirements. This should not be a one off exercise, but an active conduit that will allow estates plans to flex and respond as commissioning priorities change. The Department, in conjunction with Community Health Partnerships (CHP) and the pathfinder sites, is working to develop a standard model or models for this function.In order to secure both skills and access to external sources of capital, many PCTs opt to enter Local Improvement Finance Trust (LIFT) arrangements with a long-term strategic partner to construct and operate newly built and refurbished estate.

LIFT

A.22 PCTs are shareholders in their LIFTCo, which then has exclusive access to the PCTs' future pipeline of schemes for a defined period of time. Figure 6 sets out the structure of a typical LIFTCo.

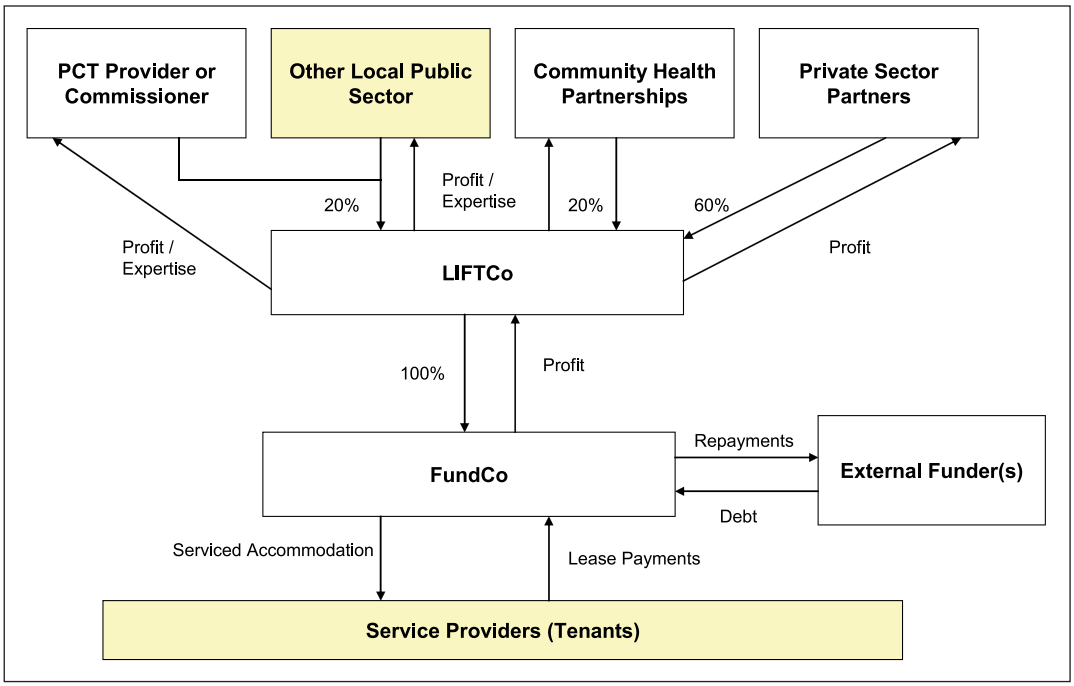

Figure 6: Overview of a LIFTCo

A.23 LIFT currently covers half of all PCTs and a new wave of Express LIFT offering faster, simpler procurements is being rolled out across the remainder. Readers should refer to Community Health Partnerships for further information regarding access to LIFT.

A.24 LIFT has proved successful in delivering very high quality accommodation, particularly in areas of significant health inequality and deprivation. PCTs have the opportunity to call off a variety of estates development services under the general definition of partnering services, although whether some of these can be called off without further competition will depend on the particular circumstances of the original procurement in question.

A.25 LIFT in its current incarnation provides a ready-made solution for the delivery of new projects. However, in achieving a satisfactory commissioner/provider split, PCTs need to find a way to ensure that existing estate is managed efficiently and that there is a direct relationship between commissioners' intentions and the way in which existing estate is sold, remodelled and reconfigured.

Strategic Estates Development Models

A.26 A number of PCTs are investigating how their entire estates needs can best be met and the Department is supporting a range of pathfinder sites to see how Strategic Estates Development models (SEDs) may be configured. Figure 7 sets out the structure of a typical SED model.

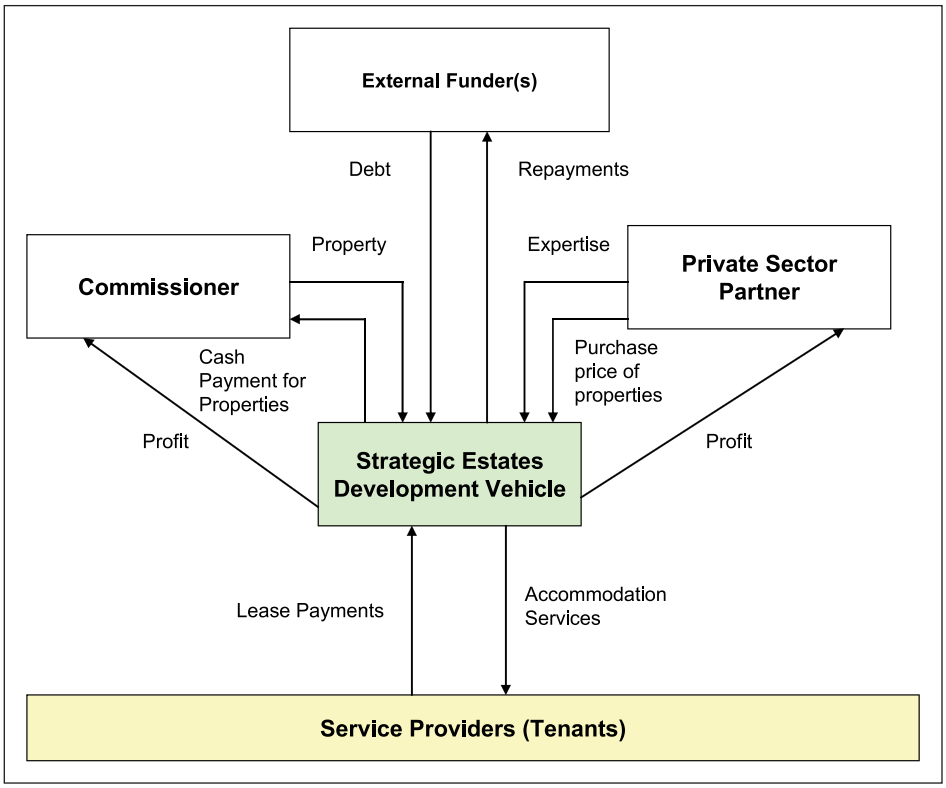

Figure 7: Strategic Estates Development Model

A.27 SEDs are sometimes referred to as "OpCo/PropCo" models, in which the core private sector element of the structure is further subdivided into a property company (that raises finance and undertakes property development transactions) and an operating company, which leases and maintains property.

A.28 Key features of a SED are:

> the ability to operate estates management on an arm's length basis from a commissioner;

> the ability to extract locked in value from existing estate and use the proceeds to remodel and redevelop it;

> to raise finance from external funders.

A.29 These functions are similar to LIFT, albeit focused more towards existing estate. The Department is currently taking advice in relation to procurement law, to establish whether LIFT is able to provide access to the services and supply chain needed to make an SED model work effectively or, if this is not possible, how SED can be established to work alongside LIFT. Alternatively, PCTs without LIFT may opt to procure their own stand-alone partner.

A.30 The Department is in the process of assembling and running a pathfinder cohort of SED schemes in order to test out issues of vires, procurement law, accounting and value for money. The results of these pilots will be communicated in due course.

A.31 The degree to which cost and affordability dominate the evaluation of estates management options depends on a number of issues including: the value of backlog maintenance inherited by the PCT, the extent to which current estate is fit for purpose in terms of location and functionality and the combined effect of these on the operational effectiveness of the estate.

A.32 In general terms, the more severe the inherited issues, the more attractive long term partnering options such as LIFT (alone or in combination with SED) are, because they offer the best chance of being able to exploit and release any locked-in value so that it can be redeployed more productively elsewhere. The more standardised the estates solution, the lower the transaction costs (in terms of legal and financial advisers' fees) in setting it up. LIFT, as a product sanctioned by the Department of Health, operates in accordance with a standard contractual model and hence has lower transaction costs. As a shareholder, the PCT may offset dividend income against the costs of leasing LIFT buildings.

ProCure21

A.33 The PCT may consider using the ProCure21 National Framework for the provision of any proposed new builds. The model, which has been developed by the Department of Health, already has national coverage. It enables a PCT to appoint a construction partner – a Principal Supply Chain Partner (PSCP) without the need to go through the OJEU process, by appointing a partner from the existing framework. The Principal Supply Chain Partners have extensive experience in meeting the needs of NHS Clients and use healthcare planners and others within their supply chains, who can assist with the development of capital projects where the client does not have extensive in house expertise.

A.34 The Programme utilises best practice in public sector construction as set out by Her Majesty's Treasury and the Office of Government Commerce. It has a good track record of delivering good quality NHS facilities across both the Acute and Primary Care Sectors on time and within budget.

A.35 The current framework agreement has been extended until September 2010.

Value for Money Constraints

A.36 Value for money must lie at the heart of any decision relating to the use of taxpayers' resources, either locked down in the form of infrastructure or in liquid form as lease payments. Value for money is based on a blended assessment of various risks, rewards (eg flexibility) and their associated costs expressed in qualitative and quantitative forms then projected forward over time. It does not necessarily follow that the least costly solution is automatically value for money, when all relevant risks and benefits have been costed and included in the analysis. Departmentally sanctioned products, such as LIFT, have built in levels of risk transfer by virtue of standard contractual documentation and specifications. Estatecode contains detailed value for money guidance.

Accounting Issues

A.37 According to the legal form in which they are held, and the degree of control that a PCT is able to exercise over them, assets may be classed as on or off balance sheet. On balance sheet assets incur capital charges in the form of depreciation and cost of capital. Many PPPs, are classed as off balance sheet, which may have a number of advantages in terms of avoiding certain operating costs and the finite limits placed over on balance sheet capital investment.

A.38 However, it has been a long standing HM Treasury principle that value for money should be the primary determinant of whether or not a given form of property holding should be undertaken, not its accounting treatment. From the point of view of the commissioner/provider split, if PCTs opt for LIFT or SED models, then they will need to understand the way in which they will be accounted, as this materially affects PCTs' balance sheets and income and expenditure.

A.39 This is a highly technical area and whilst high level guidance can give an indication of which element of a financial structure are significant in determining its accounting treatment, expert accounting advice should be sought before irrevocably committing to a transaction.

Legal Constraints

A.40 PCTs will need to ensure that any infrastructure model that is developed is intra vires – in other words, that the PCT has the power to adopt such a model and enter into any necessary contractual arrangements. PCTs currently have the power to enter into LIFT joint ventures, but any other joint venture arrangements would need to be approved by the Secretary of State.

A.41 There are strict limitations over PCTs' ability to dispose of their operational estate and in these circumstances even the transfer of estate to a joint venture (such as that envisaged by the SED model or LIFT) would be classed as a disposal. Subject to a number of legal tests, operational estate can only be disposed of at the point it can be classed as surplus. This may occur from a PCT's point of view, at the point of separation into commissioner and provider services because the operational estate ceases to be necessary for the commissioner to carry out its functions. Transfer of assets to a joint venture or LIFTCo would be classed as a disposal; hence, how and when assets are deemed to be surplus is highly significant in terms of the ability to exploit certain structures such as SED or LIFT.

A.42 However, if infrastructure is passed across to the provider service it is at once inextricably bound up with the performance of the provider's core functions and may cease to be surplus. It is then far more difficult to dispose of property on anything but a piecemeal basis, which could significantly curtail the ability of the commissioner to make major step changes in the quality, location and occupation of key parts of the estate.

A.43 Therefore, in order to maintain the maximum freedom of choice, commissioners should plan on the basis that they will retain direction over estate and that providers should be tenants, not owner-occupiers.

A.44 The exact degree to which commissioners retain day-to-day (as opposed to strategic) involvement in the provision of estate depends on the model of provision that is adopted. However, a PCT will need to be sure that any infrastructure model that it wishes to adopt is intra vires; that the PCT has the necessary power to develop and adopt such a model and enter into any necessary contractual arrangements. For example, whereas specific legislative powers exist enabling a PCT to enter into a LIFT joint venture arrangement, such powers do not currently exist to allow a PCT to enter into an alternative joint venture arrangement. The Secretary of State would need to delegate this power to PCTs generally, or to specific PCTs, for this to be possible.

A.45 A PCT will also need to ensure that it complies with the EU procurement rules when entering into any new contractual arrangement.

A.46 Where a PCT has entered into a LIFT arrangement, it may be unable to enter into a new arrangement to deliver its estate requirements without breaching the exclusivity terms of its LIFT contract. Where this is the case, the use of LIFT and/or the form that any proposed strategic estates development model is able to take will depend on the exact terms of the LIFT contract and the terms of the tender process that was originally undertaken by the PCT.

A.47 Commissioners will always need to take appropriate legal advice in relation to these issues and, as mentioned above, the Department is also considering some of these issues centrally through the pathfinder projects.

Sustainable development

A.48 Sustainability is taking a more significant role in the management of assets within the NHS. Legislation, regulations and guidance are now focused on sustainable development and the use of sustainable materials.

A.49 Better design and energy efficiency are being demanded, together with the provision of renewable energy sources such as microgeneration and biomass heating sources.

A.50 NHS organisations should ensure that they (and their partners, for example in LIFT and PFI schemes) are kept up to date on this important matter.

A.51 To meet mandatory ministerial energy targets, NHS organisations should achieve 35-55 GJ/100 m3 energy performance for all new capital developments and major redevelopments/refurbishments; and 55-65 GJ/100 m3 for existing facilities. Also, the NHS should reduce the overall level of primary energy consumption by 15% or 0.15 MtC (million tonnes carbon) from March 2000 to March 2010.

A.52 The Secretary of State has initiated the development of an Energy Efficiency and Carbon Reduction Strategy for the NHS. This strategy will build on the existing success of the NHS on energy to position the NHS at the forefront of cross Government action on climate change while saving significant amounts of money and improving the health and economy of local communities. The strategy is currently being developed by the Sustainable Development Unit.

A.53 While the Department has commissioned work to calculate the current carbon footprint of the NHS and they are working with the Carbon Trust to extend its carbon management programme to all NHS organisations. In addition, NHS organisations will be encouraged to implement the NHS Good Corporate Citizen Toolkit, giving an immediate process measure across all aspects of sustainable development.

Sale or lease of premises at a concessionary price or rent

A.54 Treasury guidance recognises that in certain cases, it may be reasonable for a public body to accept a price or rent below market value, where such a transaction would achieve operational and/or wider public benefits that outweigh price/rent considerations alone. In all cases, the benefits must be clearly identified in a supporting business case. For example:

> A prospective purchaser may offer to provide services or other benefits to an NHS body eg a charity using a property for a hospice. Where these benefits can be quantified in monetary terms and the figure is equal to or exceeds the open market value, then it can be deemed that the best price has been secured and the sale can proceed.

> A lease may be granted at a rental level below market value to any organisation proposing to use all or part of an NHS site for services that complement the NHS service or would otherwise have to be provided by the NHS. The value of the concession must be justified by the expectation that any financial loss will be matched by an equivalent financial or service benefit.

A.55 The NHS organisation concerned must approve any concessionary sale/rent in full knowledge of the business case for the concession. If the value of the concession exceeds £250,000, or if the transaction may be seen as novel or contentious, approval must be sought from the Department of Health. Where approval is to be granted the case must be reported to Parliament and recorded as a 'gift'. The accountable officer and, where appropriate, a health minister would have to be prepared to defend the sale as a deliberate concession.

Securing the NHS interest

A.56 In the case of a freehold disposal, an overage or clawback provision should be negotiated and secured by a legal charge, in case the purchaser subsequently sells at a higher price. In the case of a leasehold transaction, the lease should clearly state the proposed use of the property, and provide for a reversion to the NHS, if it ceases to be used for the purposes stated. Assignment or subletting should also be barred. Full details of concessionary sales and leases are available in the DH publication "Health Building Note 00-08: Estatecode".

Appendix 2 – Issues for staff

Introduction

A.57 This annex deals with the key employment aspects that need to be considered when developing and taking forward organisational change in community services. This annex:

> Sets out good practice in taking forward change through staff engagement;

> Sets out the requirements and expectations in relation to transferring staff to new organisational forms.

The national Social Partnership Forum is currently reviewing the impact and potential impact of staff transfers and is planning to issue further advice and guidance in due course. The NHS Constitution sets out the broader context in respect of staff rights.

Development of Proposals and Consultation

A.58 Developing and implementing plans for change with the involvement of the workforce is critical to achieving an effective outcome. The importance of maintaining good communication and working effectively with trade union representatives and staff, from the beginning of the change management programme, cannot be underestimated. It is often the "softer" HR aspects such as effective communication, effective listening and timely engagement that provide for a positive outcome or otherwise. Often there is an underestimation at the start of the process about the time and effort that maintaining good communications might take so it is critical that this be well planned with realistic timescales. However, if handled well, many longer-term benefits can arise. Conversely, if workforce issues are not well handled then difficulties that could arise will take more time and effort to resolve or at worst could jeopardise the success of the proposals. Good communication is key to ensuring that workforce implications are carefully considered and included in any planning.

A.59 Beyond the formal requirements set out in a range of legislation dealing with formal consultation and staff representation requirements – The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE (2006)), Trade Union and Labour Relations (Consolidation) Act 1992 (TULCRA (1992)) & Information and Consultation of Employees Regulations 2004 (ICE (2004)). This includes a requirement that early consultation and engagement with staff and their trade union representatives should be a part of any initial consideration, appraisal and development of proposals for the future

delivery of services provided by PCTPSs. This should be conducted within the spirit and emerging practice of social partnership. All organisations providing NHS services are obliged to have regard to the NHS Constitution which includes rights and responsibilities of staff as well as pledges to staff including on engagement.

A.60 Early consultation and engagement with staff and their representatives, trade unions representatives, is a requirement in any initial consideration, appraisal and development of proposals for the future delivery of services provided by PCTPSs. Such engagement may take effect through established forums, such as a Joint Consultative Committee established pursuant to Section 26 of the Agenda for Change terms and conditions of service handbook for those NHS staff covered by Agenda for Change or through the local Social Partnership arrangements.

A.61 It is recommended that SHAs share PCT business and workforce plans, in relation to their intentions for provider function, with the trade unions through the Social Partnership Forum. This is most critical where there is to be a TUPE transfer of staff, as both SHAs and trade unions will need to discuss workforce and consultation plans of those PCT's which are divesting themselves of their provider functions.

A.62 The Department of Health and trade unions believe that this sharing of information at SHA SPF level will facilitate more effective outcomes for both staff and the service.

Equality

A.63 No employees should receive less favourable treatment on the grounds of age, gender, marital status, race, religion, creed, sexual orientation, colour, disability, working patterns or trade union membership. The basis of law for these protections comes from the provisions regarding unlawful discrimination on the grounds of race, sex, disability and trade union membership contained within the Race Relations Act 1976 (as amended), the Sex Discrimination Act 1975 (as amended), the Disability Discrimination Act 1995, the Trade Union and Labour Relations (Consolidation) Act 1992 (as amended) and the Employment Equality (Age) Regulations 2006.

A.64 It is important to remember that NHS Organisations have a public sector duty to undertake an assessment of the impact on equality of any change. Employers should undertake an equality impact assessment to evaluate the impact of change on the workforce. The legislation supporting equality impact assessments is the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005, and the Equality Act 2006.

A.65 Non-NHS providers will also be covered by the public sector duties through their contractual relationship with the NHS. PCT commissioners will need to work with and support non-NHS organisations to ensure that those duties are complied with.

Issues relating to transfer of staff

A.66 The NHS Constitution sets out the six NHS values (respect and dignity, compassion, working together with patients, commitment to quality of care, improving lives, and everyone counts). The Constitution and accompanying handbook set out the legal employment rights of staff working on NHS funded services, together with pledges to staff and staff responsibilities. The NHS Constitution should be embedded in the contractual arrangements with providers.

A.67 The following section sets out in more detail the statutory framework for staff transfers along with expectations that relate specifically to NHS funded services. Staff and their trade union representatives should be made aware of the impact on their terms and conditions of the proposed transfer. The legislation concerning transfers of staff is set out in the Transfer of Undertakings (Protection of Employment) Regulations 2006, commonly known as the TUPE regulations.

Protection of pay and terms and conditions

A.68 In every circumstance except for continuation of provision by the PCT, there is likely to be a change of employer. It is current government policy, encapsulated in the Cabinet Office Code on Workforce Matters in Public Sector Contracts[31], that in situations where public sector staff transfer the intention is that TUPE should apply. In circumstances where TUPE does not apply in strict legal terms, the principles of TUPE should be followed and the staff involved should be treated no less favourably than had the Regulations applied. The Cabinet Office Code should be embedded in the contractual arrangements with providers.

A.69 Also relevant are the Secretary of State's statutory powers to transfer staff to or from an NHS organisation set out in paragraph 8 of Schedule 4 to the NHS Act 2006 (transfer of PCT staff to a new NHS Trust taking on a PCT hospital or other facility).

A.70 There are specific information and consultation obligations in TUPE Regulation 13. Consultation must take place with recognised trade unions. The Cabinet Office Code also identifies that:

> "Where the service provider recruits new staff to work on a public service contract alongside staff transferred from the public sector organisation, it will offer employment on fair and reasonable terms and conditions which are, overall, no less favourable than those of transferred employees. The service provider will also offer reasonable pension arrangements."

[31] March 2005, see www.archive.cabinetoffice.gov.uk/opsr/workforce_reform/code_of_practice/index.asp

A.71 In the event of a transfer of an undertaking or activity (i.e. the transfer of a service), TUPE would apply to protect the existing terms and conditions of public sector staff who transfer to the new entity. In effect this means the new employing entity is placed in the same position as the old employer (i.e. the PCT in terms of most employment rights and obligations.

A.72 Public sector transfers have been made increasingly employee friendly as a consequence of the Statement of Practice on Staff Transfers in the Public Sector (and its Annex – Fair Deal for staff pensions) ("COSOP")[32] and the Code of Practice on Workforce Matters in Public Sector Service Contracts (the "Code").

A.73 The combined effect of TUPE, COSOP and the Code is that:

Under TUPE:

> Staff transfer on their existing terms. So, in the case of NHS staff, they will transfer on their current NHS terms and conditions;

> Transferring employees' terms and conditions remain intact and can only be changed in narrow circumstances that are for economical, technical or organisational reasons (ETO) in the new organisation;

> Affected employees must be informed and consulted about the transfer of their employment, via their union/employee representatives;

> Trade Union recognition in respect of the transferred employees also transfers if the organisation undertaking transferring retains its distinct identity from the remainder of the new employer's business;

> There is protection for transferring employees from dismissal in connection with the transfer; and

> Certain employee information must be passed from the original employer to the partner.

A.74 TUPE protections apply to employees who are wholly or substantially engaged in an undertaking or activity (or part of an undertaking or activity) which transfers, as well as on second and subsequent transfers.

[32] Cabinet Office Statement of Practice on Staff Transfers in the Public Sector 2000

A.75 The TUPE regulations include:

> The duty to inform and consult representatives.

> Timing needs to be long enough to ensure meaningful consultation.

> Information to be shared with representatives to include, the fact of transfer, when it will occur, reasons for the transfer, legal, social and economic implications, measures which transferor or transferee will take and, if no measures, then that fact stated.

> Consideration must be given to representations made and responded to. There is a legal penalty on failure to consult which could be up to 13 weeks pay for each employee affected.

A.76 Under COSOP and the Code, new joiners who work alongside transferred staff should be offered fair and reasonable terms and conditions, which are overall no less favourable than those of transferred staff, essentially to avoid a "two-tier workforce". This is a requirement of the Cabinet Office Code.

Pensions

A.77 Transferred employees should be offered secure pension provision in the form of access to a pension scheme which is broadly comparable to the public sector scheme which they are leaving, with new joiners being entitled to a good quality employer pension scheme or a stakeholder pension scheme.

A.78 To be eligible to be a member of the NHS Pension Scheme a person must be either an officer (i.e. a person employed by an employing authority which is defined below) or a dental or medical practitioner or trainee. An employing authority includes:

> an NHS organisation established under the 2006 Act;

> any other body constituted under the health acts and sanctioned by the Secretary of State;

> a registered medical practitioner; or

> persons providing piloted services.

A.79 Where staff transfer to a GP practice as practice staff, they will continue to have access to the NHS Pension scheme as officers. However, they will not have access to the NHS Injury Benefit Scheme nor to early retirement on grounds of redundancy. Early retirement on redundancy is covered by TUPE and so equivalent arrangements would have to be provided by the contractor in the event of a redundancy. The contractor will be expected to provide a scheme similar to the NHS Injury Benefits scheme.

A.80 Where the staff do not continue in the direct employment of the NHS organisation and staff transfer from NHS service to the service provider then the requirements of the Cabinet Office Statement of Practice "A Fair Deal for Staff Transfers in the Public Sector" (Fair Deal) will apply. There is a very clear guide for staff entitled "What happens to my pension" and this could be used to support the consultation process.

A.81 If Fair Deal applies, the new employer will be required to make available to the employees who transfer from NHS employment a pension scheme which is, in the opinion of the Government Actuary's Department, broadly comparable to the NHS Pension Scheme at the point the employees transferred.

A.82 Fair Deal is also clear that it applies on transfers from public sector employment to independent sector providers and on transfers between public sector employers and public sector service providers and makes explicit reference to the protection of the transferring employees' pension rights.

A.83 Certain employers other than NHS employers are also allowed to participate in the NHS Pension Scheme and these employers are known as Direction Employers as their participation is by virtue of a direction by the Secretary of State under either section 7(1) or 7(2) of the Superannuation (Miscellaneous Provisions) Act 1967.

A.84 Section 7(2) Direction Employers are mainly charities, voluntary bodies, medical schools, overseas employers, or certain care in the community bodies who wish to continue membership of the NHS Pension Scheme. Approved social enterprises may also have access to Sect 7(2) Directions.

A.85 A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community. It should therefore:

> be trading

> have social objectives

> and with surpluses reinvested in its primary purpose or community

A.86 The following legal forms will be acceptable, as long as they meet the agreed criteria above:

> a Registered Charity (which can be a company limited by guarantee but not usually by shares)

> a Community Interest Company (which can be a company limited by guarantee or shares)

> an Industrial and Provident Society

A.87 As Social Enterprises are independent organisations they do not have direct access to the NHS pension. However, DH policy allows Social Enterprises to be direction employers, this means that staff transferring from an NHS organisation can transfer on their current terms and conditions including continued access to the NHS Pension Scheme (see details on direction employers above). This protection will continue to apply on job change or promotion providing they continue to be wholly employed by the SE on NHS work. Employees transferring from elsewhere or existing employees who voluntarily choose employment with the SE, will not be given access to the NHS Pension Scheme and their terms and conditions should comply with the Cabinet Office Code to avoid a two-tier workforce situation.

A.88 Not all statutory pension schemes are comparable to each other and specific advice will be required where staff transfer between schemes established under the Superannuation Act 1972.

A.89 Where staff are being transferred outside the NHS, contracts should enshrine the protections set out in this section for transferred staff as well as new joiners.

A.90 It is also possible that staff currently employed by the PCT may wish with other staff to set up a partnership of members of the NHS family. Employees of such an organisation would be given access to the NHS Pension scheme as practice staff. Shareholders, who are not GPs but who are members of the NHS family, would be treated as non-GP providers. Non-GP providers are final salary members of the NHS Pensions scheme. However, they are treated as full time regardless of the hours they actually work and are not able to pension income from any other NHS source. Currently they are only able to pension NHS income from a PMS or SPMS contract. GP shareholders would be pensioned under the practitioner arrangements.

HR Policies and Practices

A.91 Where staff transfer outside the NHS, contracts should set out expectations with regard to access to training and all statutory requirements (eg health and safety, equal opportunities legislation) which should be enshrined in contracts.

A.92 New provider organisations will be expected to show that they have an appropriate HR strategy and workforce plan within their business model which underpins their capacity and capability to deliver any prospective contract. This would include having a robust HR strategy proportionate to the size of the organisation. This will cover how they intend to recruit and retain good quality staff. As a benchmark the strategy should incorporate how they intend to provide well-designed jobs, a development and training plan for staff, a cohesive approach to staff health, safety and well-being, and a constructive plan for staff engagement and partnership. They will also need to demonstrate how they will meet their public sector duty with regard to equality. All employers should be encouraged, through service contracts, to adopt standards of good practice in respect of matters such as partnership working with trade unions where recognised, grievance, disciplinary, flexible working, and dignity at work policies. Such expectations would need to be proportionate for smaller organisations.

Continuous Professional Development

A.93 Providers should be able to demonstrate a commitment to promote equality of access to Continuous Professional/Personal Development through:

- the identification of a named Board member (or lead partner) with responsibility for oversight of education and development;
- a comprehensive education and training investment plan linked to the organisation's strategic plan;
- identification of the education and development needs of every member of staff, underpinned by clear definition of their role or job plan (using the KSF outline where appropriate);
- annual appraisal and personal development planning;
- systematic recording of all employer-approved CPD activity;
- using the Electronic Staff Record (ESR) or other workforce data collection system;

- a robust system of feedback to evaluate the effectiveness of CPD activities in relation to service delivery and patient care including appropriate feedback from staff and patients;
- improved transparency of investment in CPD through annual publication of agreed key metrics on access and expenditure;
- an annual report to the Board on staff development and CPD activity.

A.94 All organisations contracting with, or employing, health care professionals, need to have in place the clinical governance and appraisal systems necessary to enable individuals to provide the evidence needed to revalidate their professional registration.

Staff Engagement

A.95 Every provider of community services should carry out staff experience surveys at least once a year. Details of arrangements for such surveys should be made available to the Co-ordinating Commissioner on request. The provider should publish a summary of staff survey results and actions in response to the results.

A.96 Statutory rights in relation to union membership should also be respected. These include:

- the right to access and make use of the services offered by their union at an appropriate time;
- not to be penalised or treated unfairly by their employer for joining a union or taking part in union activities at an appropriate time;
- legal rights include the right not to be dismissed, selected for redundancy, penalised or treated unfairly by their employer on the basis that they do – or don't -belong to, or are thinking of joining, a trade union;
- Union members facing a disciplinary or grievance hearing have a right to be accompanied by a union representative or official, provided that they make a reasonable request to their employer to be accompanied;
- The right for a union to be recognised for collective bargaining purposes.

A.97 New provider organisations will be expected by the commissioner of the service to clarify their approach to the continuing recognition of existing trade unions, in line with the principles set out in the NHS Constitution and 2007 NHS Partnership Agreement.

Workforce Planning

A.98 Local Health and Social Care organisations are at the heart of the workforce planning system, as they are best placed to assess what is required to deliver the healthcare services that their local population need. Employers will be responsible for planning their workforce based on PCT's service commissioning plans and should be sharing their workforce plans with PCTs. SHAs will have a key oversight and aggregation role, and are responsible for managing the MPET budget (in full) and commissioning education and training. Arrangements should be made by PCTs to ensure the integration of workforce planning with all new providers, including in the provision of student placements and posts for newly qualifying health professionals. New providers must be prepared to play their part in sharing these responsibilities along with existing NHS providers.

Redundancy

A.99 If the service changes proposed involve redundancies, (whether post or pre implementation of the change) then further consultation will be required under the Trade Union and Labour Relations (Consolidation) Act 1992, section 188 if at least 20 redundancies are envisaged at one establishment within a period of 90 days. If ICE has not been formally adopted consultation should follow the requirements of the TULCRA 1992. Consultation is recommended in all cases even if there are less than 20 jobs at risk. Consultation must take place with recognised unions. It must take place in relation to a number of specified issues, such as ways of avoiding dismissals and mitigating the consequence of dismissals and must be "with a view to reaching agreement". Even where no redundancies are envisaged to take place, changes to terms and conditions which entail termination of existing contracts of employment (so that new contracts can be issued to staff with the new terms) will also trigger the statutory consultation obligation.

A.100 The table attached sets out the terms for transferring staff and new joiners under each of the organisational models envisaged for community services.

Community services staff moving from existing NHS PCT provision to...

	NHS vertical or horizontal integration eg with acute trust or Community FT direct provider	Profit or non-profit sharing partnership of NHS family (non GP providers)	LA Partnership Section 75 Partnership Arrangement	Third Sector SE, charity, voluntary body	Private Sector
Terms & Conditions – Existing staff at point of transfer.	Retain NHS T&Cs.	Depends on whether the member of staff is a shareholder or employed by the partnership. Shareholders may be entitled to a % of the profits of the contractor as well as retaining their T&Cs in place prior to the transfer. Staff employed by the contractor would be protected by TUPE.	Retain NHS T&Cs.	TUPE protects existing NHS T&Cs. Future changes to NHS T&Cs and pay may or may not be automatic depending on contractual arrangements.	TUPE protects existing NHS T&Cs. Future changes to NHS T&Cs and pay may or may not be automatic depending on contractual arrangements.

	NHS vertical or horizontal integration eg with acute trust or Community FT direct provider	Profit or non-profit sharing partnership of NHS family (non GP providers)	LA Partnership Section 75 Partnership Arrangement	Third Sector SE, charity, voluntary body	Private Sector
Terms and Conditions – New starters.	Automatically entitled to NHS T&Cs.	The partnership is obliged to adopt Cabinet Office Code and offer T&Cs which are no less favourable than those of transferred employees.	Offered either LA or NHS T&Cs.	The new employer is obliged to adopt the Cabinet Office Code and offer T&Cs which are overall no less favourable than those of transferred employees.	The new employer is obliged to adopt the Cabinet Office Code and offer T&Cs which are overall no less favourable than those of transferred employees.

	NHS vertical or horizontal integration eg with acute trust or Community FT direct provider	Profit or non-profit sharing partnership of NHS family (non GP providers)	LA Partnership Section 75 Partnership Arrangement	Third Sector SE, charity, voluntary body	Private Sector
Pensions – Existing staff at point of transfer.	Retain full membership.	Depends on whether the member of staff is a shareholder or employed by the partnership. Shareholders are classified as non-GP providers – they retain access to the final salary section of the Pension Scheme but are treated as full time regardless of the hours worked. They also retain entitlement to IB but are no longer entitled to Compensation for Premature Retirement Regulations as well as the Pension Scheme Regulations dealing with early retirement pension (redundancy etc).	Retain full membership.	May apply for SofS direction or alternatively must satisfy provision of Fair Deal for Pensions and offer a GAD certified "broadly comparable" pension scheme.	Fair Deal for Pensions requires that the new employer offers a GAD certified "broadly comparable" pension scheme.

	NHS vertical or horizontal integration eg with acute trust or Community FT direct provider	Profit or non-profit sharing partnership of NHS family (non GP providers)	LA Partnership Section 75 Partnership Arrangement	Third Sector SE, charity, voluntary body	Private Sector
		Employees retain membership of the NHSPS excluding entitlements under the Injury Benefit and Compensation for Premature Retirement Regulations as well as the Pension Scheme Regulations dealing with early retirement pension (redundancy etc). The Partnership is required to provide alternative arrangements for early retirement due to redundancy, IB and Compensation.			

	NHS vertical or horizontal integration eg with acute trust or Community FT direct provider	Profit or non-profit sharing partnership of NHS family (non GP providers)	LA Partnership Section 75 Partnership Arrangement	Third Sector SE, charity, voluntary body	Private Sector
Pensions – New starters.	Automatically enrolled in NHSPS unless opt out.	NHSPS only. Excludes entitlements under the Injury Benefit and Compensation for Premature Retirement Regulations as well as the Pension Scheme Regulations dealing with early retirement pension (redundancy etc).	Either Local Government or the NHSPS (through a Secretary of State Direction) – dependent on the circumstances of the individual at time of recruitment.	The Cabinet Office Code requires the new employer to offer reasonable pension arrangements – either membership of a good quality employer pension scheme or a stakeholder pension scheme.	The Cabinet Office Code requires the new employer to offer reasonable pension arrangements – either membership of a good quality employer pension scheme or a stakeholder pension scheme.

Summary

A.101 Below is a checklist of key issues to be addressed:

> Agree process and timescales for effective engagement with staff and their trade unions.

> Identify formal requirements of legislation, i.e. TUPE (2006) , TULCRA (1992) & ICE (2004) and build them into your process or project plan.

> Undertake an Equality Impact Assessment.

> Consider the impact of the NHS Constitution and Handbook and the Cabinet Office Code and ensure these are embedded in any contractual process.

> Consider the impact of the 'Fair Deal' for Pensions and other pensions implications of any proposed transfer.

> Identify both the legal and best practice requirements in relation to Human Resources policies and practice.

> Identify the requirements to promote equality of access to Continuous Personal Development.

> Consider how provision for staff experience surveys at least once a year can be delivered and that staff's trade union rights are protected.

> Consider how arrangements will be made to ensure the integration of workforce planning with all new providers.

Appendix 3 – Involving stakeholders

Involving clinical leaders

A.102 The *Primary and Community Care Strategy*[33] set out a vision in which clinical staff are central to driving change to improve quality, access and health outcomes. The Department of Health is committed to the development of clinical and leadership skills and resources to deliver high quality evidence based care and is currently developing six 'transformational attributes' for practice and leadership, one of which is clinical staff as leaders of service transformation across multi-disciplinary teams and organisations.

A.103 This will prepare practitioners for leading, developing and working in, 'transformed' community services able to deliver locally organised personal care in partnership with people and communities, promote health and reduce health inequalities, continuously improve services and support integration of care across organisational boundaries.

A.104 A number of methods will be used in co-production with the NHS including an action-learning methodology to engage professionals, the public and other interested parties at the outset so that commitment, realism and acceptability is built in from the start.

Consulting patients and other stakeholders

A.105 Major stakeholders in designing and shaping the future of health and social care are patients and carers, NHS staff, trade unions and the wider public. This is especially important in the sphere of community services as so much of the care delivery is in highly personalised settings.

A.106 The draft NHS Constitution[34] underlines the fact that public and user involvement should be part of the fabric of the NHS by setting out a right for people to be involved: "You have the right to be involved, directly or through representatives, in the planning and development of local services." Further detail will be provided on this when the NHS Constitution is published in its final form.

A.107 NHS bodies must comply with their duty under section 242(1B) of the NHS Act 2006, and have regard to the related guidance given under section 242(1G) of the Act. Under this legislation, users must be involved in the planning of services and in the development and consideration of proposals to change services, where such proposals may affect the range of services offered or the manner in which they are provided. For example, users should be involved in the development of a range of options for the way community services could be provided within a PCT area, not just asked for their opinion on a model that has been developed by health professionals and managers.

[33] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008
[34] *The National Health Service Constitution*, published for consultation, Department of Health, June 2008

A.108 Users must be involved where a decision will change the way a service operates if the change affects the manner in which those services are delivered or the range of services offered. There is no requirement to involve users where proposals for change or a decision to be made by an NHS organisation, for example a change of provider, does not result in changes to the service that affect the way in which that service is delivered or the range of services available.

A.109 Statutory guidance on section 242(1G) of the NHS Act 2006 , along with advice and general guidance on how NHS organisations can carry out involvement activity, including through LINks and partnership working, is available in *Real Involvement: working with people to improve health services*.[35]

A.110 If there is no impact on the range of services or the manner of their provision, there is no legal requirement under section 242 (1B). However, there may be a separate obligation to consult with the Overview and Scrutiny Committee(s) under section 244 or it may be good practice to carry out involvement activities, rather than it being a legal requirement. In addition to the duty to involve under section 242, PCTs have an obligation to consult their local authority overview and scrutiny committees if they are considering any proposal for a substantial development of the health service in their area or a substantial variation in the provision of that service.[36]

Involving staff

A.111 The workforce is a key part of any organisation and to any service reconfiguration. The importance of maintaining good communication and working effectively with trade unions should not be underestimated. It is often the "softer" HR aspects such as effective communication, effective listening and timely engagement that provide for a positive outcome or otherwise. Good communication is key to ensuring that workforce implications are carefully considered and included in any planning.

A.112 Early consultation and engagement with affected staff and their representatives, including trade unions, are a requirement in any initial consideration, appraisal and development of the employment arrangements. Such engagement may take effect through established forums, such as a Joint Consultative Committee established pursuant to Section 26 of the Agenda for Change terms and conditions of service handbook for those NHS staff covered by Agenda for Change or through the local Social Partnership arrangements. Effective and early consultation with trade unions is a cornerstone to managing change effectively, and the degree of consultation and engagement should be discussed and agreed with the trade unions, with consideration given to services being reconfigured and which staff groups are affected.

[35] Department of Health, December 2008

[36] See regulation 4(1) of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002

A.113 Although not directly part of the duty imposed by section 242(1B) the NHS Act 2006, it is good practice for commissioners and providers to involve staff and others working in the NHS such as GPs, allied health professionals, nursing staff and hospital consultants, many of whom will be key partners from early on in an involvement process. It is also possible that staff may be users in which case NHS organisations have a duty to involve them under section 242(1B).

A.114 It is important for staff to recognise and understand the different ways in which they might be involved. Under section 242(1B) they might be involved as:

> users of services, and

> representatives of users of services.

A.115 They might also be involved as practicing clinicians in their professional capacity although there is no obligation on NHS organisations under section 242(1B) to involve them in that capacity.

A.116 There should be clinical support and leadership for all major changes to health services. Further information on how to do this, along with further guidance on involving staff in decisions, is available in *Real Involvement: working with people to improve health services*.

A.117 Useful sources of law and guidance covering the employment aspects of change are provided in Appendix 2.

Appendix 4 – Applying the right to request for a social enterprise

A.118 The Department of Health will provide centrally a high-level business case template for staff to use to exercise the right to request. This will need to be read in conjunction with *Social Enterprise: Making a Difference*. From Spring 2009, staff will be able to access business support from accredited providers.

A.119 PCTs will assess the right to request against their service and supply-side strategy and against nationally co-produced criteria designed to help PCT understanding of the social enterprise element of the request. Expertise on social enterprise will be available to PCTs at this stage.

A.120 The PCT Board makes a decision on the request. The SHA approves the PCT assessment and the decision. If the PCT Board approves the request:

> the PCT supports the development of a full business case

> the full business case is subjected to national due diligence processes to test its commercial and financial viability

> the social enterprise is established and it is suggested it runs in shadow form for six months, prior to award of the contract

> the contract for services, or AWPP status, is awarded

> Property is not transferred to the social enterprise

> an agreement is reached on a 'going concern' value if there is an early sale

> the PCT signals how it will promote choice and competition, eg, through systematic market-testing, or entry by other AWPPs, etc.

A.121 If the social enterprise (or CFT) application fails or is withdrawn, the PCT commissioner retains responsibility for the services provided and will need to ensure continuing service delivery. One option may be to open up the market to other potential providers.

A.122 If the PCT does not approve the request, the SHA reviews the decision.

A.123 The Social Enterprise Unit will provide guidance and access to specialist advice for any PCTs and their staff who are considering a social enterprise.

Appendix 5 – Applying for Community Foundation Trust status

A.124 We are piloting the application of the foundation trust model to providers of community services, as one of a range of options for community provision. Community Services NHS FTs (CFTs) will deliver services that are currently provided by the PCT sector (though they would not necessarily correspond to existing PCT providers, perhaps covering larger geographical areas or focusing on specific patient groups.

A.125 The legislation that governs the way FTs are created was written with NHS Trusts in mind and PCT providers cannot apply for foundation status directly. In order to create a CFT, the PCT provider services must be separated from the rest of the PCT (legally the provider arm is constituted as a committee), run at least for 12 months as an autonomous function and then must be set up as an NHS Trust, which then formally makes the FT application.

A.126 The application process remains the same for the PCT provider as with any FT applicant. SHAs via their assurance process will put forward FT applicants to be considered by the Applications Committee and Secretary of State approval will need to be sought and the decision to authorise lies solely with Monitor.

Glossary

Any Willing Provider	A set of system rules whereby, for a prescribed range of services, any provider that meets criteria for entering a market, can compete for business within that market
Any Willing PCT-accredited Provider	An AWP model whereby PCT commissioners give accreditation to providers who meet specific requirements, additional to the requirements for safety and quality that need to be met in order to be registered with the Care Quality Commission, to meet local needs
Arm's Length	Principle whereby parties to a transaction are demonstrably independent of each other – at arm's length, i.e. not subject to undue control or influence
Capital Expenditure	Spending on assets for continuing (mid- or long-term) use within an organisation, e.g. buildings, machinery, equipment
Commissioning for Higher Quality and Innovation	This scheme will be a simple overlay to the Payment by Results system, forming part of commissioning contracts
Community Interest Company	Limited company structures with special features designed for social enterprises which want to use their profits and assets for the public good, not just for private gain
Competition Panel	An independent final review panel to rule on allegations of breaches of the competition principles and rules which will govern the procurement and provision of NHS services from October 2008
Corporate Joint Venture	A venture between two or more parties that results in the creation of a new corporate body
Corporation tax	Tax levied on the profits of limited companies
Depreciation	In accounting, a method of spreading the total cost of an asset over its entire useful life (especially where this is longer than one year), rather than recognising the whole sum at once
Discount rate	Rate, usually expressed as a percentage, by which future costs and revenues are reduced to reflect their present value, recognising the time value of money

Discounting	Acknowledging the time value of money, by finding the present value of future costs and revenues. This is usually done by applying a discount rate to each unit of time by which payments or receipts are delayed
Divestment	The process of selling off subsidiary business interests or investments
Due Diligence	Process during which the financial strength of a company is checked and an overall assessment is made to ensure that information supplied by the target organisation is acceptable
Employment Standards	See Appendix 6 for details of these
Franchise	An agreement by which the right to supply a service is awarded to a provider. There are three main types of Franchises: i) *Management Franchise* is the right to provide the management function of an NHS organisation; ii) *Operating Franchise* is the right to operate an NHS organisation; and iii) *Branding Franchise* is the right to use an NHS organisation's name and associated intellectual property, including but not limited to logos, trademarks and other branding materials
Independent Sector	Any organisation that is not an NHS organisation or Social Enterprise or any other public sector body or a Third Sector organisation
Joint Venture	An agreement between two or more parties to undertake economic activity together. This may take the form of a contractual joint venture or an incorporated joint venture
Limited liability company	A limited liability company is a body corporate with its own legal identity separate from its owners (or members); their own financial liability is limited to the amount of share capital they have invested
Limited Liability Partnership	A partnership which has its own legal personality separate from that of the partners (unlike traditional partnerships, where partners have unlimited liability for the partnership's debts)
Local Involvement Network	Organisations to be established from April 2008, replacing patient forums, with the aim of organising patient involvement in NHS decision making
Monitor	The independent regulator of NHS Foundation Trusts

Options appraisal	Detailed consideration of financial and non-financial factors – costs, benefits, potential risks etc. offered by different options identified as part of the decision-making process as to whether and how to go ahead with a particular proposal
Overview and Scrutiny Committees (OSCs)	Committees of Local Authorities which inquire into all 'matters of local concern' including the NHS. NHS organisations must consult with OSCs before making any material changes to service offerings, and must provide the OSCs with any information requested
PCT provided services (PCTPS)	Variously known as DPO, APO, etc, this is the arm of the PCT which provides community services which is in a contractual/SLA relationship with the PCT commissioner
Private Finance Initiative	A financing method in which a public body (i.e. a trust) contracts with a private sector consortium through a special purpose vehicle. Contracts have a capital expenditure and a servicing component
Service lines	The NHS equivalent of a commercial company's business units. They are the key units within which services are delivered to patients, with discrete resources used to meet a related set of patient needs
Social Enterprise	A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community rather than being driven by the need to maximise profit for shareholders and owners
Strategic Options Appraisal	Process through which the pros and cons of various different strategies are assessed
Third Sector	Charitable, voluntary, not-for-profit sector (i.e. neither public nor private)
TUPE legislation	Legislation preserving employees' terms and conditions when a business or undertaking, or part of one, is transferred to a new employer
VAT exempt	Goods and services are VAT exempt when the supplier does not charge VAT, but cannot himself recover VAT incurred on his costs
VAT zero-rated	Goods and services are zero rated when the supplier does not charge VAT, and is also able to reclaim VAT incurred on costs
Vires	Legal powers granted to NHS organisations and other public sector bodies by parliament

Abbreviations

AWP	Any Willing Provider
AWPP	Any Willing PCT-accredited Provider
CEO	Chief Executive Officer
CIC	Community Interest Company
CNST	Clinical Negligence Scheme for Trusts
COSOP	Cabinet Office Statement of Practice on Staff Transfers in the Public Sector
CPD	Continuous Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning for Higher Quality and Innovation
CSCI	Commission for Social Care Inspection
DCSF	Department for Children, Schools and Families
DH	Department of Health
ETO	Economical, Technical or Organisational
EU	European Union
FPC	Final Business Case
FT	Foundation Trust
GAD	Government Actuary Department
GIS	Geographic Information System
HC	Healthcare Commission
HR	Human Resources
I&E	Income and Expenditure

ICE	Information and Consultation of Employees Regulations 2004
IM&T	Information Management and Technology
IB	Injury Benefits
JV	Joint Venture
LA	Local Authority
LIFT	Local Improvement Finance Trust
LINks	Local Involvement Networks
LLP	Limited Liability Partnership
MBO	Management Buy-out
MPET	Medical and Professional Education and Training
NHS CFT	NHS Community Foundation Trust
NHS FT	NHS Foundation Trust
NHSPS	NHS Pension Scheme
OJEU	Official Journal of the European Union
OSC	Overview and Scrutiny Committee
PBC	Practice-based commissioning
PCT	Primary Care Trust
PCTPS	PCT provided services
PESTLE	Political, Economical, Sociological, Technical, Legal and Environmental
PFI	Private Finance Initiative
PMS	Personal Medical Services
PPP	Public Private Partnership
SE	Social Enterprise

SED	Strategic Estates Development
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
SLA	Service Level Agreement
SPF	Social Partnership Forum
SPMS	Special Personal Medical Services
SWOT	Strengths, Weaknesses, Opportunities and Threats
T&Cs	Terms and conditions
TULCRA	Trade Union and Labour Relations (Consolidation) Act 1992
TUPE	Transfer of Undertakings (Protection of Employment) Legislation
VAT	Value added tax
VfM	Value for Money

The Transforming Community Services guidance series has been developed to enable the delivery of innovative, modern, responsive and evidence-based community services of a consistently high standard, and improve the organisations providing community services, and the processes underpinning them, to ensure they are fit for purpose.

Titles in the Transforming Community Services guidance series include:

- Framing the contribution of allied health professionals
- Social enterprise: a guide to the right to request
- Standard contract for community services (published as an annex in the Operating Framework 2009/10)
- Currency and pricing options for community services
- World class commissioning resource pack for commissioners of community services
- Enabling new patterns of provision
- Review of information models and next steps
- Business readiness for PCT provision

Available soon:

- Guidance on information models for community services (Spring 2009)
- Quality framework for community services (Summer 2009)
- A series of transformation guides for clinical services (Summer 2009)
  - High quality care for children and families
  - High quality care in services for long term conditions
  - High quality care in acute services closer to home
  - High quality care in services for rehabilitation and long term neurological conditions
  - High quality in end of life care
  - Promoting health and well being and reducing inequalities

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291850 1p 1K Jan 09 (ESP)
Produced by COI for the Department of Health

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