SHAPING PCT PROVIDER SERVICES

The future for community health

Candace Imison

The King's Fund>

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London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2809
Email: publications@kingsfund.org.uk
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About the author

Candace Imison is Deputy Director of Policy at The King's Fund. Candace joined The King's Fund from the NHS, where she was Director of Strategy in a large acute trust. Candace has held a number of senior management and board-level roles within NHS providers and commissioners.

She worked on strategy at the Department of Health between 2000 and 2006. During this time she led work on the configuration of services, future health care trends, workforce and the patient experience.

She contributed to the White Paper *Our Health, Our Care, Our Say*, as well as *Keeping the NHS Local* and the Wanless Review. She also led a major modernisation initiative for the Modernisation Agency, *Hospital at Night* (2003–4). Candace holds a Masters degree in Health Economics and Health Policy from Birmingham University. Her first degree was from Cambridge University, where she read Natural Sciences.

Candace worked on a part-time secondment to The King's Fund from 2007, becoming Deputy Director of Policy in early 2009. She was one of the authors of the recent report from The King's Fund on polyclinics, *Under One Roof*.

Acknowledgements

Foreword

Finding the right place and organisational form for community health services has been a conundrum that the National Health Service (NHS) has puzzled over for more than a quarter of a century. Since leaving local authority control in 1974, community health services have been lodged in numerous temporary homes.

The organisation of community health services is now back on the agenda following Lord Darzi's NHS Next Stage Review (Darzi 2008; Department of Health 2008b). Darzi's diagnosis was clear: community health services have a vital role to play in delivering care closer to people's homes, but they are not yet fit for purpose. Better information, stronger management and more expert commissioning are all needed if community health services are to realise their potential.

The inadequacies of primary care trust (PCT) provision are fundamentally intertwined with those relating to PCT commissioning. The management of significant provider arms has distracted PCT boards from their core commissioning role (and the recent national assessment of PCTs' world class commissioning competencies has demonstrated that there is a need for urgent improvement). The commissioning role of PCTs is now rightly taking precedence over that of provision.

Lord Darzi was clear that patient choice and provider competition should apply equally to community health services as to hospital services. After so long in the backwater of NHS reforms, community health services are now about to enter the mainstream and become a critical part of NHS reform. For as long as PCTs continue to provide community health services, they face a conflict of interest as commissioners that could prevent them from obtaining the very best services for their populations.

Community services are currently provided as local monopolies in an era in which competition is increasingly the preferred policy instrument. The implications of this are significant. Simply transforming a PCT monopoly into an independent monopoly will not meet the wider governmental objectives of patient choice. A more sophisticated solution is required, and time is against us.

Future options for community services abound. Independent social enterprises are one solution favoured by the government. So too are 'integrated care organisations' based on general practices. All the while, hospital foundation trusts wait in the wings, ready to take advantage of new opportunities to extend their scope into community-based care.

So, the leaders of PCTs and of PCT-provided services face numerous challenges and much uncertainty. It was against this backdrop that Ernst & Young and The King's Fund co-hosted an expert seminar at the end of 2008 to consider how this challenge might be met. The debate that was sparked by this seminar has helped to shape this report.

The report makes some telling points, among them:

- invest in developing the right leaders
- clarify roles and responsibilities before embarking on organisational change
- make full use of the technology available to drive greater productivity.

These points may seem obvious, but they are often conveniently forgotten as systems go through change. As a consequence, the policy ambitions behind organisational change are rarely realised.

Perhaps the key point, however, is that there is no single 'right answer' that PCTs should be aiming for. The challenges set out for community health services can be met in different ways and should take account of local circumstances. If this transformation is to be successful, local leaders must be given enough elbow-room to craft their own approaches.

Richard Lewis
Director, Ernst & Young Health Advisory Practice and Senior Associate, The King's Fund

Alpesh Patel
Head of Healthcare, Ernst & Young

Summary

The pattern of community health service provision has changed little since the inception of the National Health Service (NHS) in 1948. Specialists sit in hospitals, GPs sit in their surgeries, and community health service staff are largely peripatetic, frequently detached from both primary and secondary care.

Community health services have suffered from many years of inattention and underinvestment. As a consequence, the services provided vary widely in terms of performance and productivity, and the necessary facilities and support, both managerial and technological, are often lacking.

In addition, community health services face a growing number of more complex and dependent patients as disease patterns shift from acute to chronic conditions. Improving the standards and 'fit' of community health services will not only improve the quality of life for many of the most vulnerable, but will also be critical to creating a sustainable health care system that can meet growing demands within cash limits.

The NHS Next Stage Review (Department of Health 2008b) highlighted the need for modernisation within community health services. It recommended '…removing what are still unwarranted variations in quality of care…' (Department of Health 2008b, p 42), and stated: 'It is a central part of our strategy… that we support the NHS and community clinicians in transforming these services and according them equal status to other NHS services' (Department of Health 2008b, p 43).

The Review also signalled the separation of the commissioning and provider functions of primary care trusts, a separation that is seen as a precursor to improvement not only of PCT provider services but also of commissioning. The NHS operating framework for 2008/9 (Department of Health 2007e, p 32) requires: '…all [primary care trusts] should create an internal separation of their operational provider services, and agree service level agreements for these, based on the same business and financial rules as applied to all other providers'.

The Department of Health's recent enabling guidance entitled *Transforming Community Services: Enabling new patterns of provision* (Department of Health 2009), requires PCTs to come up with a strategy for community services and to identify future organisational options by October 2009, a relatively short time frame.

The imperative to map out a future for primary care trust (PCT) provider services gives PCTs the opportunity not only to create the much-needed focus on commissioning, but also to realign their local health care system to address the needs of some of the most vulnerable in their population, particularly those with long-term or disabling conditions. It should provide the stimulus to make good the years of inattention and underinvestment in community health services.

This report draws on learning from previous reorganisations of community health services, and attempts to integrate their provision, including that of mental health services. We investigate what will help to drive the transformation in community health services that is demanded by the changing pattern of disease.

Although the Department of Health guidance exhorts PCTs to put quality first and does not prescribe a future organisational model, the timescale for change is relatively short. There is a risk that, given the other demands created by the world class commissioning agenda, PCTs will focus on delivering new organisational models and miss a critical opportunity to modernise and improve services. Lessons from previous reorganisations show that new organisational structures will not of themselves deliver benefits, and might present problems if cultural and workforce issues are not addressed. Benefits arise from the core values, leadership and processes that underpin any new structure.

Of course, this should not be seen as a reason for retaining the status quo: change is needed more than ever, and the current drive for reform provides a real opportunity to map out a new, more focused, future for community services. It should also give PCTs the opportunity to concentrate on commissioning high-quality care that is based on good evidence of what works and provides good value for money.

Key recommendations

Our review of the evidence from previous attempts to reorganise and integrate community health services, including mental health services, offers some clear indications of the areas that require PCT attention if the much-needed service transformation is to be achieved. These include the following.

Learn the lessons from history

- Simply redrawing organisational boundaries will not alone deliver the change required.

- Strong leadership at national and local level is necessary to deliver change.

- The links with primary care are critical, and need to be strengthened as part of any solution; the primary care consortia emerging out of practice-based commissioning offer new opportunities to forge and strengthen these links.

Draw on the evidence offered by successful models of integrated care

- Focus on process as much as on structure.

- Pay attention to the human and cultural dimension of change, including ensuring that:
  – there is a widely understood set of values and principles to underpin the new ways of working
  – there is a clear focus on the patient groups who use these services
  – the key enablers for effective teamworking are in place.

- Ensure significant input from general practitioners (GPs).

- Contestability can act as an impetus to service improvement.

Improve performance and productivity

- Clarify referral pathways for both general and specialist services.

- Clarify the roles and responsibilities of individuals and teams.

- Ensure there are systematic approaches to caseload management.

- Provide a service that is needs-led rather than demand-led, for example by using case-finding tools.

If some community services are to provide a genuine alternative to hospital care, they need to be able provide round-the-clock support (24/7), with close working between all those offering support in the out-of-hours period.

Service portfolio, resources and infrastructure

- When considering the future of services, group together those that have strategic coherence.

- Review the community estate, and ensure that it supports the desired model of care in a high-quality therapeutic environment.

- Ensure staff have the technological support necessary to improve productivity and overcome the barriers between primary, secondary and social care.

- Ensure workforce plans take account of a growing and ageing population, along with loss of staff due to retirement.

Options for the future organisation of services

A high-level review of the options for the configuration of services in the future demonstrates that there is no single 'right' answer. Any option will require new ways of working if it is to deliver more effective and co-ordinated care. Different solutions will suit different local circumstances and different services. Given the challenges of merging organisations, the 'virtual integration' approach might be an easier first step for some services.

Whichever option is chosen, there will need to be strong and clear-sighted commissioning founded on outcome-based criteria, which should drive the pattern of service provision. Partnerships with the private sector or social enterprise models could provide opportunities to encourage innovation and improve motivation and performance.

1 Introduction

> *In terms of an opportunity to do good, this is a huge opportunity.*
>
> (Expert seminar participant, November 2008)

High Quality Care For All: NHS next stage review final report (Darzi 2008) signalled the separation of the commissioning and provider functions of primary care trusts (PCTs) in England. This, and subsequent guidance, encourages PCTs to introduce contestability into the provision of community health services under the 'any accredited willing provider' model.

Future organisational options range from social enterprises to commercial organisations, as well as a variety of National Health Service (NHS) provider models, including a community foundation trust. The current service provider of PCTs – community health services – employs 250,000 staff, which represents one-fifth of the NHS workforce in England (Department of Health 2008b). This means a significant proportion of NHS staff experiencing organisational uncertainty and possible job insecurity.

In January 2009, the Department of Health published *Transforming Community Services: Enabling new patterns of provision* (Department of Health 2009). This best practice guidance sets out a timetable for change: by October 2009, PCTs must have outlined their plans for 'transforming' community services and identified their preferred governance arrangements.

This report aims to help PCTs as commissioners and their community providers to consider the future configuration options. It draws on the experience gained from previous reorganisations of community health services, and attempts to integrate their provision, including that of mental health services, as well as assessing what steps will be necessary in order to deliver the transformation in community health services that is demanded by the changing pattern of disease. In addition, the report has incorporated the views expressed at an expert seminar held to reflect on the issues faced by PCTs and policy-makers as they plan the way forward for community health services. Appendix A (*see* pp 31–35) summarises this seminar and gives a list of participants.

Over the past 60 years, the disease burden has shifted from acute to chronic conditions; more complex and more dependent patients present community health services with a growing challenge. Yet many staff feel poorly equipped to address this increasing workload (Cook 2006). The pattern of provision has changed little since the inception of the NHS in 1948: specialists sit in hospitals, general practitioners (GPs) sit in their surgeries, and community health service staff are largely peripatetic, detached from both primary and secondary care. As a consequence, care is often fragmented, with a focus on acute or post-acute symptoms (Wilkin 2002).

The final report of the NHS Next Stage Review, *High Quality Care for All*, urges the NHS to adapt to the changing needs of the population: 'The NHS and all of its many partners must respond to this shifting disease burden and provide personalised care for long-term conditions… We need to make this goal a reality' (Darzi 2008, p 28).

The subsequent NHS Next Stage Review policy document (Department of Health 2008b) highlighted the need for modernisation within community health services. It recommended '…removing what are still unwarranted variations in quality of care…' (Department of Health 2008b, p 42), and stated: 'It is a central part of our strategy… that we support the NHS and community clinicians in transforming these services and according them equal status to other NHS services' (Department of Health 2008b, p 43).

The imperative thus produced to map out a future for PCT provider services gives PCTs the opportunity not only to create the much-needed focus on commissioning, but also to realign their local health care system to address the needs of some of the most vulnerable in their population, particularly those with long-term or disabling conditions. It should provide the stimulus to make good the years of inattention and underinvestment in community health services.

With this background in mind, this report:

- describes community health services, and explores their importance for those who are most vulnerable, particularly those with long-term or disabling conditions

- draws lessons from history and previous attempts to reconfigure community health services

- draws lessons from the experience of previous attempts to integrate health services, including mental health services, especially the implementation of the care programme approach and the establishing of community mental health teams

- assesses the strategic options for the future

- makes a number of recommendations for planning, at both local and national levels.

2 Community health services and their role

The community health service portfolio of primary care trusts (PCTs) encompasses a broad and complex range of services. Figure 1, below, and Table 1, overleaf, provide a high-level overview of just some of the many community-based services provided by PCTs. However, each PCT's pattern of provision is different. Alongside the services suggested here is an increasing number of specialist services designed to meet the needs of those with rarer conditions or a particular cluster of problems, and a major challenge for those who manage community health has been the lack of strategic synergy between the services in their portfolios.

The principal challenge for provider units is to tackle their lack of strategic coherence, which is a barrier to patients and referrals and a significant cause of their low productivity. Only when the provider units have sorted out their service portfolios and decided what businesses they should be in, does it make sense to develop new organisational structures.

(Manning and Setchell 2007, p 5)

Figure 1 High-level overview of community-based services provided by PCTs

Community health services

Core services:
community nurses,
health visitors

Specialist services:
podiatry, speech and language therapy,
school nursing, health promotion

Services provided with other agencies:
maternity services, mental health, children's centres,
carer support, sexual health, prison health

Source: Adapted from NHS Confederation (2009, p 3)
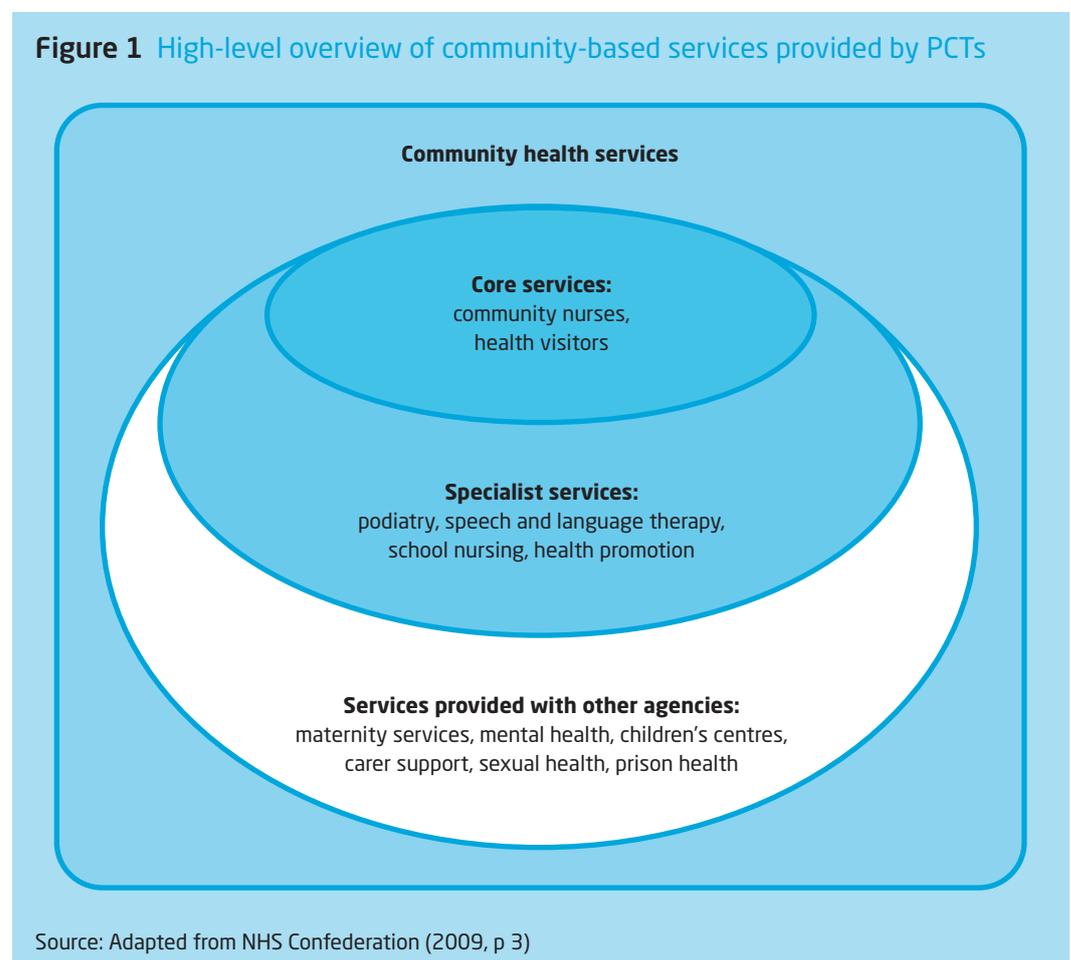
A typical community health service portfolio might include the areas shown in Table 1 below.

Table 1 Typical community health service portfolio

Children and families
■ Children with disabilities
■ Community maternity
■ Extended schools
■ Health visiting
■ Safeguarding children
■ School nursing
Rehabilitation
■ Community oncology
■ Occupational therapy
■ Orthopaedic rehabilitation
■ Physiotherapy
■ Stroke rehabilitation
Health and well-being
■ Audiology
■ Chiropody
■ Dental services
■ Family planning
■ Health promotion
■ Health trainers
■ Minor injury services
■ Sexual health services
■ Stop smoking services
Long-term conditions
■ Adult learning disability services
■ Carer support
■ Community matrons
■ Community rapid intervention services
■ Continence services
■ Diabetes services
■ District nurses
■ Intermediate care services
■ Self care
End-of-life care
■ Continuing/palliative care
■ Home support teams
■ Support for carers

Source: adapted from NHS Confederation (2009, p 4)

Broadly, community health services have a number of key functions:

■ promoting health and healthy behaviours – including supporting population screening and vaccination programmes

■ promoting independence in those with potentially disabling conditions

■ delivering treatment in a community or home setting – avoiding hospital or residential care admission where possible

■ supporting case management and disease management for those with complex long-term conditions

■ supporting rehabilitation

■ providing end-of-life care.

Table 2, below, provides a summary of the roles of some of the key staff groups within community health services, and the client groups that they support.

Table 2 Overview of the roles of community health services staff

Client group	Health visitors	Speech and language therapists	Physiotherapists	Occupational therapists	District/community nurses
	Provide early intervention, prevention and health promotion for young children and families	Assess and treat speech or language problems, or difficulties in feeding/swallowing in people of all ages	Use physical approaches to promote, maintain and restore physical, psychological and social well-being	Assess and treat physical and psychiatric conditions using purposeful activity to promote independent living	Provide nursing care for people in their own homes or in residential care homes
Babies and children	Work with children and families to address key public health priorities such as obesity, tackle social exclusion, safeguard children, support better parenting, promote infant, child and family mental health	Help babies with feeding/swallowing difficulties; work with children with a variety of physical or learning difficulties to try to bring their speech or language skills up to the level of those of their peers	Management and treatment of infants and children with a variety of congenital, developmental, neuromuscular, skeletal, or acquired disorders/diseases	Work with children who have difficulties with the practical and social skills of every day life to enable the child to be as physically, psychologically and socially independent as possible	
Adults		Help swallowing or communication problems in adults with mental health issues, learning difficulties, or physical difficulties	Diagnose, manage and treat disorders and injuries of the musculoskeletal system, including back pain and rehabilitation after orthopaedic surgery	Assess and treat physical and psychiatric conditions using specific purposeful activity and environmental adaptations and equipment to prevent disability and promote independent function in all aspects of daily life; work with a range of people including those who have physical, mental and/or social problems, either from birth or as the result of accident, illness such as cancer, dementia or a stroke, as well as those with problems associated with ageing	District nurses work with teams of community nurses and support workers to provide advice and care to patients and their carers in the community in areas such as palliative care, wound management, catheter and continence care, and medication support; the work involves both follow-up care for recently discharged hospital inpatients, and longer-term care for chronically ill patients, as well as working to prevent unnecessary or avoidable hospital admissions
End-of-life		Rehabilitate and support adults with eating/swallowing or communication problems following a traumatic event such as stroke or head injury, and those with debilitating diseases such as Parkinson's disease, motor neurone disease, multiple sclerosis, dementia, or cancer of the head, neck and throat	Help restore mobility, reduce pain, and increase fitness levels in people as they grow older, including those affected by or recovering from strokes, heart disease, arthritis, osteoporosis, cancer, Alzheimer's disease, hip and joint replacement, balance disorders, incontinence, etc		

Source: adapted from material from various sources

Community health services provide support at different points in the life cycle, but they are most often used by children, elderly people and those near death (*see* Figure 2 below).

Figure 2 Age profile of people receiving different community health services

Source: The King's Fund, adapted from Department of Health data (Department of Health 2007b)
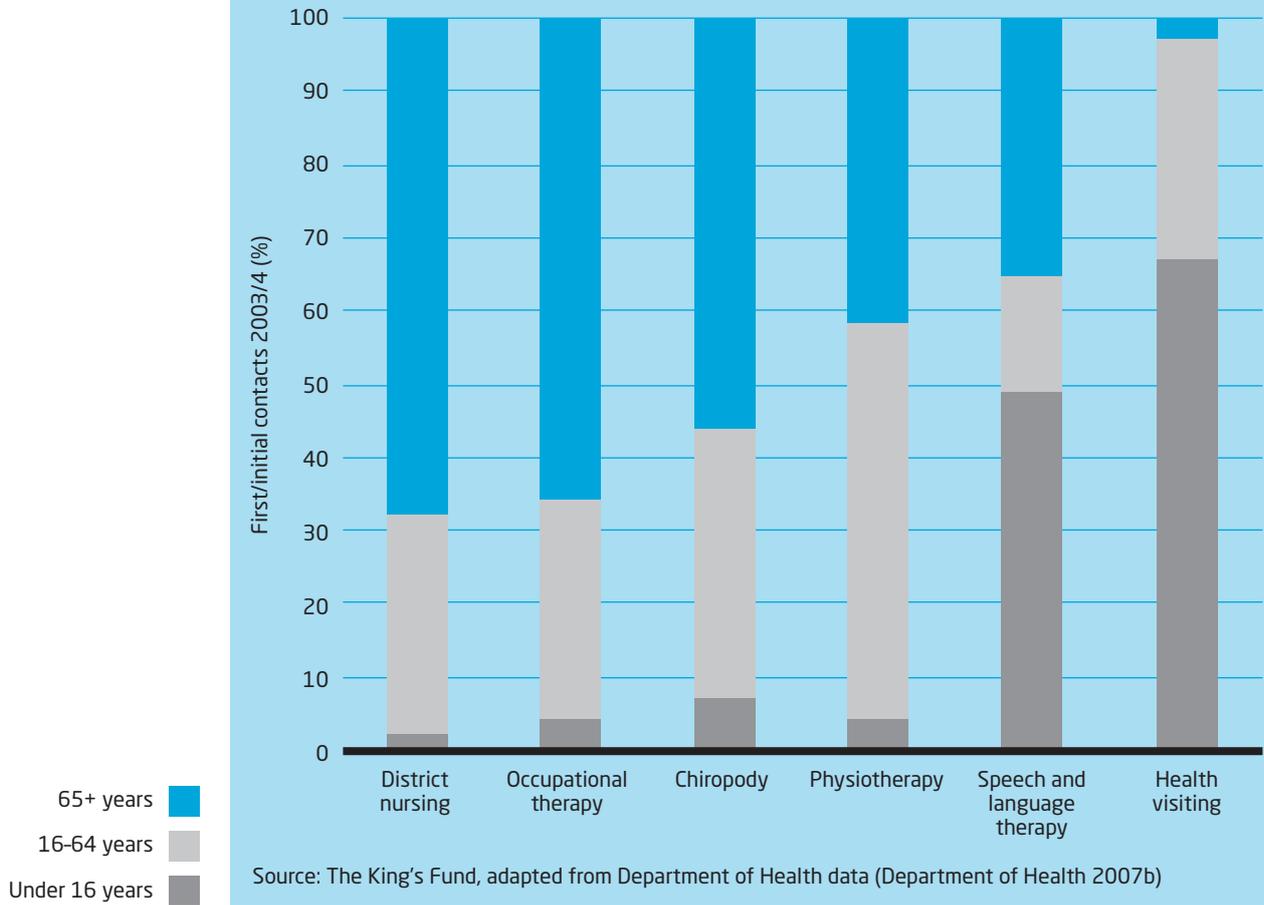
3 Community health service resources

Workforce

One-fifth of the National Health Service (NHS) workforce in England, equating to approximately 250,000 people, works within community health services (Department of Health 2008b). It is an almost entirely non-medical workforce, with more than 70 per cent being nurses or their support staff. Allied health professionals such as physiotherapists, occupational therapists and speech and language therapists, as well as community pharmacists, make up a further 20 per cent of staff (*see* Appendix B, pp 36–37).

In the eyes of some (Wilkin 2002), this separation from general practitioners (GPs) and their medical expertise has severely limited the scope for creating a unified primary and community health care system. As will be seen later, significant input from primary care physicians is a critical success factor for some integrated care models (Mukamel *et al* 2007).

Questions have been raised about whether the current curricula for community and general nursing are appropriate for the role of supporting patients in the community now and in the future (Cook 2006). Suggestions for how things could be changed include different postgraduate career paths and incentives for nurses to go immediately into a community setting. An emerging issue will be the capacity to retrain nurses currently working within the acute sector, either to work in both hospitals and the community, in order to support more integrated care, or to move into the community given the trend towards more community-based care. This idea was picked up at the expert seminar.

> *We know that services need to move into the community to deliver Darzi, but that means training and it means addressing some cultural issues… Traditionally, young people have worked in hospital and then moved into the community later in their careers, so we might want a different postgraduate career path – and we will need to use pay to incentivise.*
>
> (Expert seminar participant)

The age profile of many community health staff is comparatively old. For example, more than 30 per cent of the current district nursing and health visitor workforce are older than 50 years, and could retire within the next 10 years (Drennan and Davis 2008). Despite this prospective hole in the workforce, the commissions for training places are falling for district nurses (Cook 2006).

In the past 10 years, there has been a progressive dilution of the skill mix in community nursing services as the numbers of trained district nurses has declined while the number of registered nurses and support staff has grown (Drennan and Davis 2008). The additional investment in highly trained community matrons has also been slow to take off. Although much of the care delivered by nurses in the community is routine, such as wound care, the growing number of more dependent and complex patients requires nurses with extended and specialist skills.

Buildings and accommodation

Many community staff deliver care in people's homes. The most recent statistics available show that 85 per cent of the contacts between district nurses and patients were in patients' homes (Department of Health 2004). Although home visits will continue to be an important part of the working life of many community staff members, there is a move towards delivering care as part of a multidisciplinary team, providing 'one-stop-shop' clinics, particularly for the management of chronic disease. Some services, such as physiotherapy or audiology, need access to specialist equipment, meaning home visits are not always possible.

The buildings infrastructure of community health services is relatively poor. Despite new investment of more than £1 billion via the Local Improvement Finance Trust (LIFT), which has delivered 125 new community premises, with a further 75 on the way (Department of Health 2007d), in 2006/7 56 per cent of community hospitals were more than 30 years old, and 41 per cent were built before 1948 (Department of Health 2008a). And, although 2,848 GP premises have been refurbished/replaced since 2000, in 2007 only 40 per cent of primary care premises had been purpose-built, almost half were either adapted residential buildings or converted shops, and around 80 per cent were below the recommended size (Department of Health 2007a). The small size of primary care premises acts as a barrier to community staff working in a more integrated way with general practices.

There are also issues around the effective utilisation of community health services buildings. A recent review of LIFT schemes by The King's Fund as part of a broader review of health service buildings suggested that many peripatetic staff made poor use of valuable accommodation (Imison *et al* 2008), for example, dedicated desks being provided in community health centres for staff members who spent the majority of their working day away from the office.

Information technology

Our expert seminar also highlighted the challenges created by the lack of investment in information technology (IT). Community health services have failed to invest sufficiently in IT either to meet their business needs (which is one reason there is so little information about them), or to support clinical staff by ensuring they have access to modern electronic records or unified communication technologies.

During the research for this report, examples were given to the authors of staff returning to base after each visit to collect information and records for their next client, a practice that is wasteful and would, of course, become redundant if staff had electronic access to patient details and records.

New technologies present particular opportunities, not only to improve productivity, but also to develop new empowering models of care. Birmingham OwnHealth®, a partnership between Birmingham East and North Primary Care Trust (BEN PCT), Pfizer Health Solutions and NHS Direct, provides a good example of the care solutions offered by new technologies (*see* box opposite).

Birmingham OwnHealth®

Birmingham OwnHealth® is delivered by a partnership of BEN PCT, Pfizer Health Solutions and NHS Direct.

Birmingham OwnHealth® offers a personalised, structured programme of support for people in Birmingham with coronary heart disease (CHD), heart failure, chronic obstructive pulmonary disorder and/or diabetes. It is also developing other services to support people who have had a stroke, elderly people needing more support, and people at risk of developing cardiovascular disease (CVD).

The service is delivered over the telephone by a team of care managers, who are all fully trained and experienced nurses employed by NHS Direct. Care managers build and maintain ongoing relationships with enrolled members, providing motivation, support and knowledge to help encourage people to take action to improve their health and get the best health outcomes from treatment programmes already recommended by their GP and/or health care professional.

The care manager helps individuals to:

- understand their medical condition better

- acquire skills and knowledge and make positive lifestyle changes that can benefit their condition and overall health

- follow treatment programmes correctly as prescribed by their GPs and/or other health care professionals

- understand how to engage and use local NHS services more appropriately and effectively.

An internal evaluation of the service after one year indicated that Birmingham OwnHealth® has helped to empower people to take greater responsibility for their health and make positive changes to their health behaviours. In turn, this would appear to have had positive impact on both clinical measures and use of local health care resources.

Source: www.birminghamownhealth.co.uk/faqs (extracts)

Conclusion

The resources that community health services can call on leave them hampered, both now and in terms of future development, in a number of respects:

- the heterogeneity of services and the lack of strategic synergy has held back their development

- despite recent investment, many still lack fit-for-purpose facilities to deliver care in either a community or primary care setting, or make poor use of the facilities that are available

- they often lack the technological support that could improve their productivity and help them to overcome the organisational barriers between primary, secondary and social care

- the current age-profile of the nursing workforce in community services, taken together with the growing demand, suggest that there will be workforce and skills gaps in the future unless corrective action is taken now.

4 Community health service performance and productivity issues

This section highlights some of the performance and productivity issues faced by community health services. Overall, there is little published evidence on service quality and productivity, as highlighted by a recent review of literature conducted by the University of Birmingham's Health Services Management Centre for the National Health Service (NHS) Institute for Innovation and Improvement's Productive Community Services Programme (NHS Institute for Innovation and Improvement 2009).

There is also a lack of routine performance data. The latest statistics available for most services is 2003/4, and even this offers little insight to the qualitative aspects of what community health professionals do. The modernisation of community health services has been severely hindered by the lack of systematic data capture on services and their use. For the analysis in this report, the authors have relied on national reviews and academic studies, many of which focus on district nursing and occupational therapy services. The quality of the more specialist services is largely unevaluated.

Drawing on recent work with community health providers in England, Parker and Glasby (2008) found a workforce that generally seemed to be as dispirited and lacking in vision and purpose as their 1948 counterparts. They highlighted a considerable number of barriers to service transformation:

> …*a low level of ownership for organisational outcomes; an inability to change clinical attitude and behaviour; weak governance and accountability for patient experience and outcomes; poor innovation adoption; ill defined productivity measures; low levels of policy awareness and organisational deliverables; a low level of productive workforce engagement; a lack of strong clinical leadership and a workforce that is arguably 'change weary and reform wary'.*
>
> (Parker and Glasby 2008, p 450)

Variations in productivity, particularly in district nursing, have been identified for more than 20 years. A recent study by Jones and Russell (2007) analysed the workload of 22 district nursing teams. They found a fourfold variation in the rate of contacts made per whole-time equivalent (WTE) of staff, a variation that could not be explained by differences in case mix. There were also disparities in the contact time per WTE.

A key factor, and one found in other studies, was the way that caseloads are managed (Audit Commission 1999). Although some community teams set target timeframes for interventions and systematically review their clients to ensure they are getting the appropriate level of support, others do not, with the result that staff continue to have people on their caseload when they no longer need to be.

Confusion around roles and responsibilities is an important issue, and also a significant barrier to effective multidisciplinary working. For example: 'Many spoke of the growing confusion – even amongst district nurses themselves – about the core and enduring responsibilities that defined what it was to be a district nurse' (Cook 2006, p 9). Also:

'There is confusion amongst other professions and clients about what occupational therapy can offer and its purpose' (Herbert and Mort 1997, p 40). The literature suggests that this is an issue for most of the core professional groups within community health services (Smith and Roberts 2002; Clemence and Seamark 2003).

The lack of clarity about roles and responsibilities leads to a high rate of inappropriate referrals, which in turn results in inefficient use of resources. It also increases service users' sense of discontinuity when they invest time and energy in meeting with a professional who they then find to be unable to help them. The Audit Commission (1999) review of district nursing estimated that 10 per cent of referrals were inappropriate.

More recent studies (Cook 2006; Thomas *et al* 2006) confirm that this is still a persistent and important issue. Cook (2006) suggested that constantly changing titles and labels for staff had contributed to the confusion.

The recent Bercow Report (2008) described access to speech and language therapy services as a 'postcode lottery'. The report raised concerns that commissioners had failed to commission on the basis of local need:

> There is a wide variation in the level, type and quality of provision across the country … proper needs assessment and a focus on outcomes generally play little part in the commissioning and provision of services for children and young people with SLCN (speech language and communication needs). Variability in services appears to be due to the priority given to SLCN by each school, local authority and [primary care trust].
>
> (Bercow 2008, p 61)

In its review of district nursing services, the Audit Commission (1999) also highlighted this problem, noting that services are consequently defined by their referral base rather than by the needs of patients. Case-finding tools help to overcome this problem by proactively identifying patients who may need services, but their use is not universal.

There is an increasing expectation in England that nursing cover will be provided on a round-the-clock (24/7) basis (Cook 2006), as is the norm for community nursing in Western Europe (Verheij and Kerkstra 1992). However, there is still significant variation across England, with some services operating 24/7 and others not. This lack of 24/7 provision severely limits the degree to which services can act as a viable alternative to hospital care, although there are examples of services that demonstrate what can be achieved: in some areas a 'community at night' service brings together GP, nursing and other out-of-hours services such as pharmacies.

Conclusion

The evidence available suggests that community health services, particularly community nursing services, urgently need to address a number of performance issues. The quality of services would be enhanced if:

- roles and responsibilities were clarified
- more systematic approaches to caseload management were introduced
- the service moved towards being needs-led rather than demand-led, such as through the use of case-finding tools.

If some community services are to provide a genuine alternative to hospital care, they need to be able to provide 24/7 support, and to work closely with all those offering support in the out-of-hours period.
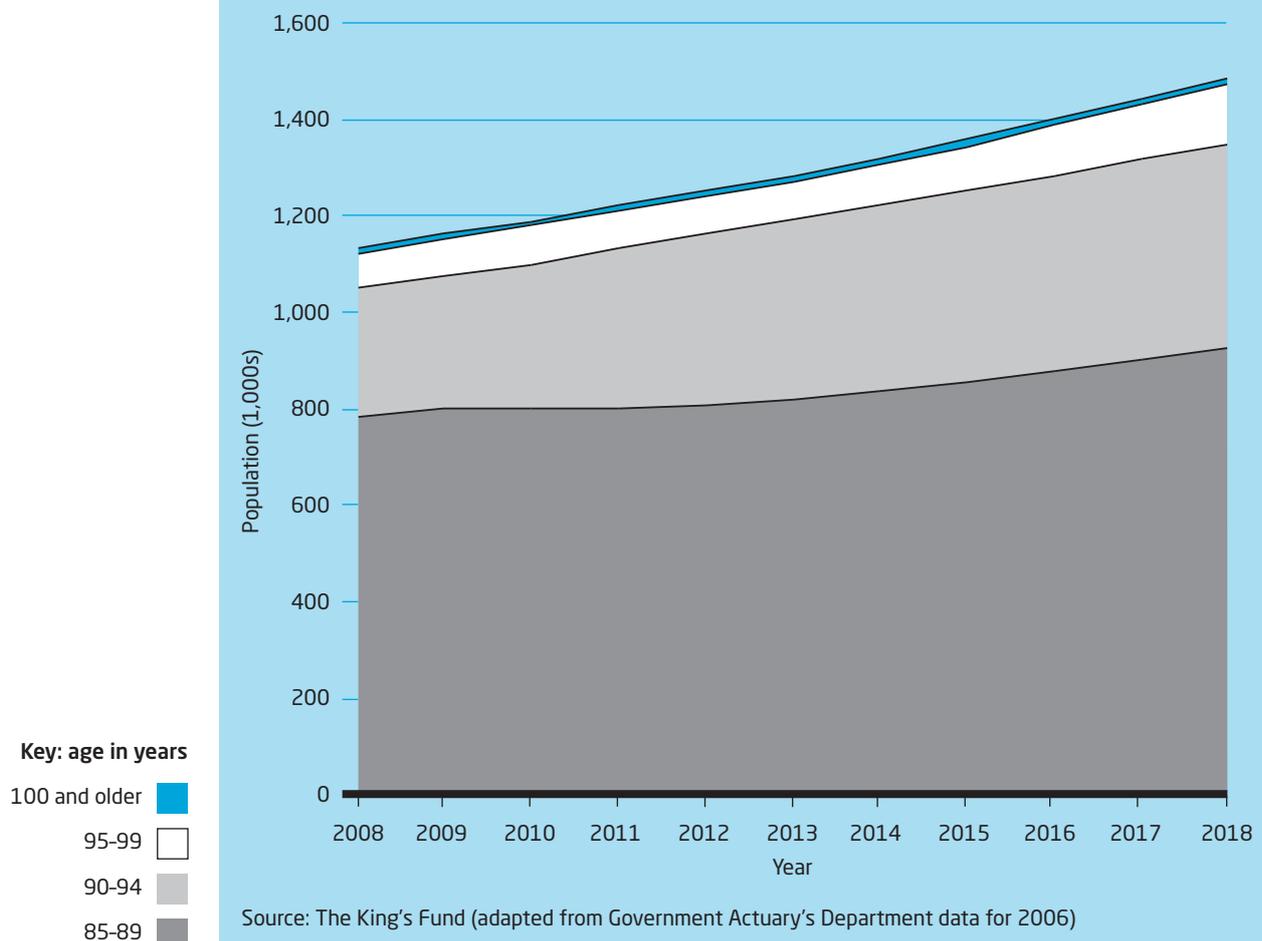
5 Addressing future needs

A number of service and demographic factors will put increasing pressure on community health services.

Both *Our Health, Our Care, Our Say: A new direction for community services* (Department of Health 2006a) and the Darzi review (Darzi 2008; Department of Health 2008b) signalled a significant shift of care from hospital to community settings, which will place increasing demands on community staff.

In addition, the demography of care is changing. We have an ageing population, and the number of very old people, in particular, is set to rise sharply: in the next 10 years there is expected to be a 31 per cent increase in the number of people older than 85 years (*see* Figure 3 below). People in this category tend to be the major users of community health services: 57 per cent of those older than 85 years are in contact with a district nurse (Department of Health 2004).

Figure 3 Projections for breakdown of population by age for England, 2008–18

Key: age in years
- 100 and older
- 95–99
- 90–94
- 85–89

Source: The King's Fund (adapted from Government Actuary's Department data for 2006)

Linked to the ageing population is the growing challenge of chronic disease: more than 60 per cent of those older than 65 years have a long-term condition. In addition, factors such as the rising rate of obesity are magnifying the impact of the ageing population (Jones 2006).

Community health services are pivotal to addressing the needs of the growing number of patients with chronic disease, and their expertise in this area is increasing, as evidenced by, for example, the specialist skills of the community matron (*see* box below) and the rising number of community nurses supporting those with specific chronic diseases such as heart failure, chronic obstructive pulmonary disease, or diabetes (Department of Health 2008c).

Community services will therefore be critical to the government's ability to deliver its pledge that: 'every one of the 15 million people with one or more long-term conditions should be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care' (Darzi 2008, p 41).

The role of the community matron

Community matrons provide advanced clinical nursing care and case management to patients with multiple long-term conditions.

They have an expert knowledge base of the physical, psychosocial, clinical and pharmacological aspects of care, and provide a holistic, generalist overview and care co-ordination for patients with multiple long-term conditions. They act as essential members of an interdependent multidisciplinary health and social care team.

The core of the role lies in the development of management plans for sick people with emerging crises or exacerbation of chronic disease, and it is therefore a position that is complex, challenging and skilled.

As clinical leaders, community matrons also need to understand and be able to negotiate the complexities of the primary, secondary and social care systems, as well as that of the voluntary sector, in order to secure the best possible care for the people on their caseload.

Source: Skills for Health

As primary care trusts make decisions about the future configuration of services, this report draws on two key areas of evidence to inform an assessment of future options.

■ Community health services have been through a variety of configurations in the past. What has been the impact of these?

■ The challenges of chronic disease management and care planning require integrated models of care. What can be learned from the evidence on developing integrated care models, particularly the experience of establishing community mental health teams and implementing the Care Programme Approach (Department of Health 1990)?

6 The historical perspective

The organisational boundary between community health services and primary care pre-dates the formation of the National Health Service (NHS). In 1911, responsibility for the administration of general practice (GP) services was given to the newly created insurance committees rather than to local authorities, despite the fact that the latter were playing an increasing role in the development of community health services. The main reason for this, and indeed the creation of the insurance committees at all, was the desire of GPs to retain their independent contractor status (Ottewill and Wall 1990). This desire for independence went on to shape the model of care throughout the NHS's history. Figure 4, opposite, gives an overview of the almost continuous organisational flux since that period.

In 1948, at the inception of the NHS, community health services were handed over fully to local authority control. From 1948 until 1974, community nursing and child health were part of the public health arm of local authorities. In 1974, they were transferred into the NHS in an attempt to tackle poor service co-ordination between hospital and community services. 'Unification is needed to… improve teamwork and ease the problem of communication. If all local health personnel worked within one local service there would be a better foundation for the provision of integrated health care' (Department of Health and Social Security 1970, paragraph 16).

Following the White Paper *Working for Patients* (Department of Health 1989), which established the first NHS trusts and the separation between commissioner and provider, community service providers progressively established themselves as separate trusts from acute providers. It was hoped that this separation would promote a shift of care towards community and primary services, and help to prevent the more powerful acute hospitals from diverting resources from community services (Greengross *et al* 1999).
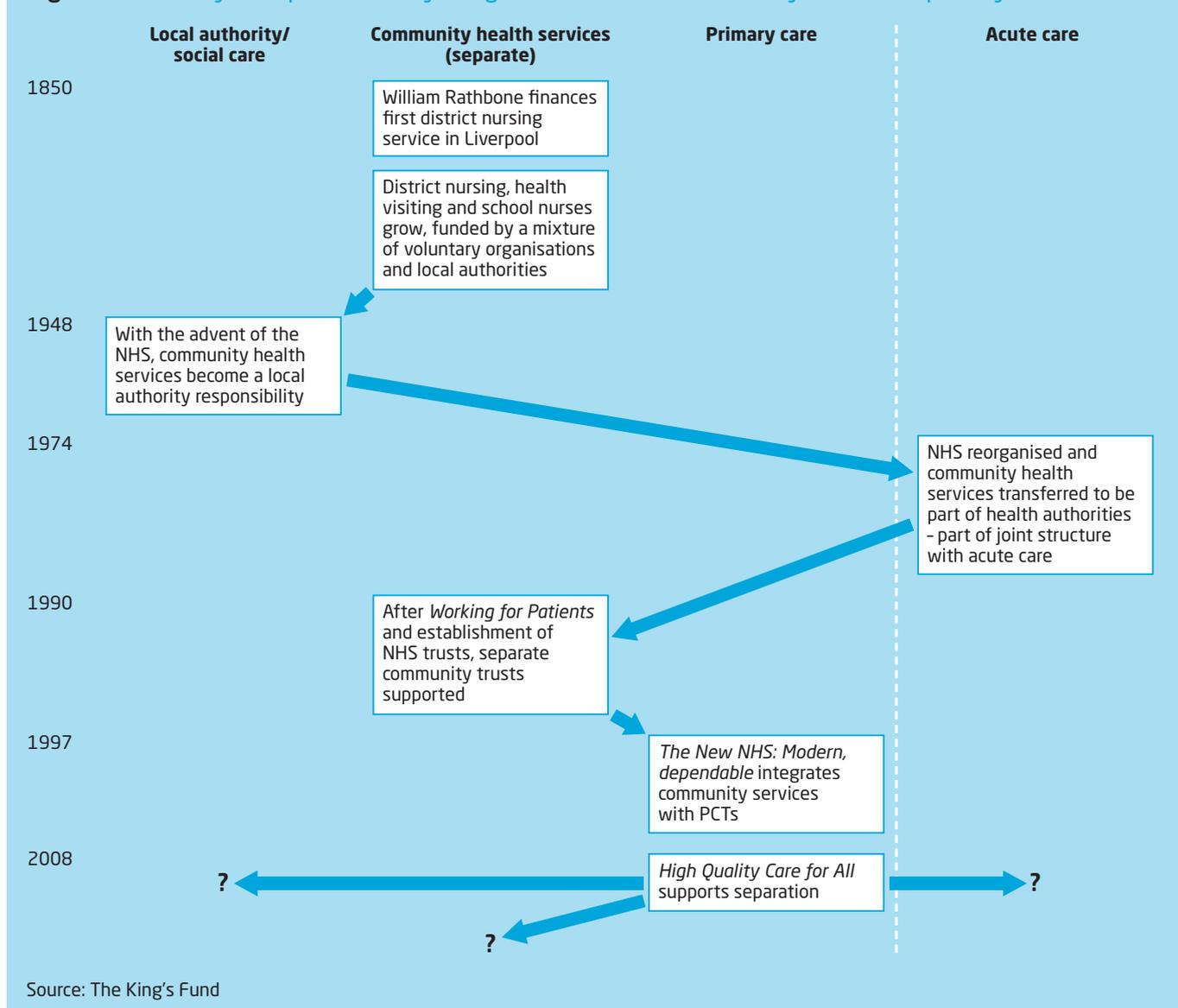
> *In the past, community services have not received priority attention at the district health authority level. Spending patterns have increased incrementally rather than been planned, and do not relate in any clear way to needs or services provided by others. Many argue, with some justification, that community services have always been the poor relation of the acute sector, suffering budget cutbacks when times are hard.*
>
> (Audit Commission 1992, p 1)

In 1997, the White Paper *The New NHS: Modern, dependable* (Department of Health 1997) signalled the future creation of primary care trusts (PCTs) that would hold fully devolved budgets and commission almost all care.

> *All of the local community should benefit from the best that primary and community health services have to offer. It is at this level – close to patients and the community – that decisions can best be taken on using the resources of the NHS to meet the health and health care needs of individual patients.*
>
> (Department of Health 1997, paragraph 5.7, p 33)

Figure 4 A history of hope? The many reorganisations of the community health and primary care services

	Local authority/ social care	Community health services (separate)	Primary care	Acute care
1850		William Rathbone finances first district nursing service in Liverpool		
		District nursing, health visiting and school nurses grow, funded by a mixture of voluntary organisations and local authorities		
1948	With the advent of the NHS, community health services become a local authority responsibility			
1974				NHS reorganised and community health services transferred to be part of health authorities – part of joint structure with acute care
1990		After *Working for Patients* and establishment of NHS trusts, separate community trusts supported		
1997			*The New NHS: Modern, dependable* integrates community services with PCTs	
2008	?	?	*High Quality Care for All* supports separation	?

Source: The King's Fund

The PCTs were given the statutory capacity to merge with community trusts, in the hope that this would result in more integrated primary and community services and improved working with social care. The paper set out that all or part of an existing community NHS trust could combine with a PCT in order to 'better integrate primary and community health services and work more closely with social services on both planning and delivery' (Department of Health 1997, paragraph 5.9, p 35).

In 2005, *Commissioning a Patient-Led NHS* signalled that PCTs should contract out community health services and that non-NHS providers could take over these services: '…the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum. We would expect all changes to be completed by the end of 2008' (Department of Health 2005).

This created widespread anxiety among a workforce that had already been through significant organisational upheaval over the preceding 10 years. After some uproar, the Department of Health wrote to strategic health authority (SHA) chief executives saying that they did not need to have plans in place by October 2005, but changes to PCT service provision would need to be completed by December 2008.

In the NHS Next Stage Review (Darzi 2008; Department of Health 2008b) there is further support for the separation of provider services, and encouragement for PCTs to consider a range of organisational models, including active promotion of the social enterprise option.

The best practice guidance document *Transforming Community Services: Enabling new patterns of provision* (Department of Health 2009) requires PCTs to resolve the future organisational model for their community services by October 2009.

Conclusion

The history of community provision is one of repeated attempts to integrate these services into the wider health care system and improve their quality. Yet many of the current challenges bear an eerie similarity to accounts written over the past 60 years of other attempts that failed to deliver. As Parker and Glasby (2008) pointed out, 'successive policy-makers seemed to subscribe to the belief that the perfect organisational structure is out there (we just have not found it yet), and that such a structure might be just one more reorganisation away' (p 449).

Why have the numerous attempts to locate community health service provision better within the health care system failed? A number of factors could be at play.

First, each shift in service from one organisational context to another has been an administrative one, largely unrelated to what patients need or what staff actually do. There has been no accompanying effort to redraw the patient pathway or build new professional relationships and ways of working. As will be seen from the evidence on health service integration and the experience of mental health services, this has been a critical issue.

Participants at the expert seminar also worried that lessons might not be learned. One said: 'I want this to be about community needs. I am really worried about people going straight to structure. [If that happened] this will just be another management restructuring.'

Second, GPs have been apart from these changes throughout, and yet they are a critical element of the team supporting people in their own home (Mukamel *et al* 2007). This could well have hampered the development of integrated, effective community health care.

Third, community health services have seldom been the focus of national or local attention. Without this attention, services have found it difficult to make the case for reform or, indeed, for additional resources. For the same reason, they have also found it difficult to attract strong and effective leadership.

7 Learning the lessons of previous attempts to integrate health care

The experience of mental health services

Over the past 20 years, mental health services have moved from a hospital-based model of care to a more community-based model. As a result, a wide range of new services has been developed in the community. Two mainstays of this new model of care have been the establishment of multidisciplinary health and social care teams – community mental health teams (CMHTs) – and a formalised approach to care planning known as the Care Programme Approach (CPA).

CMHTs first began to be established in the late 1980s, and have since been encouraged by a range of central guidance, including the *National Service Framework for Mental Health: Modern standards and service models* (Department of Health 1999). The aim of CMHTs was to ensure patients not only received more integrated care, but also that they benefited from the full range of professional skills and support available.

The CPA was introduced in 1990 as a framework for the care of people with mental health needs in England (Department of Health 1990). The key elements were the systematic assessment of individuals' health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker/care co-ordinator to monitor the delivery of care, and the regular review of the care plan to ensure it reflects the changing needs of service users.

This section looks at the lessons that community health services can draw from these two developments, both of which have struggled to fulfil their original ambition to support more personalised and integrated care.

The CPA has been reviewed several times since 1990, most recently in 2006 (Department of Health 2006b). The result was new guidance entitled *Refocusing the Care Programme Approach: Policy and positive practice guidance* (Department of Health 2008d). One of the strongest elements of feedback from the review process was the need for the values and principles that underpin CPA to be articulated and to unite staff around a common approach. The statement of values and principles included in the latest guidance (*see* box overleaf) resonates with that which might be applied to anyone with a long-term need, whether mental or physical.

Statement of values and principles in *Refocusing the Care Programme Approach: Policy and positive practice guidance* (Department of Health 2008d, p 7)

The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self-determination to help people maintain control over their own support and care.

Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of relationship between service user and care co-ordinator is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, teamwork and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Source: reproduced from *Refocusing the Care Programme Approach: Policy and positive practice guidance* (Department of Health 2008d, p 7)

The importance of an elevating goal and set of core values is also critical to the successful functioning of a team. The ingredients for successful teamworking are well documented but hard to achieve in practice. According to Larson and LaFasto (1989), key components include:

- a clear, elevating goal
- an effective team structure with clear channels of communication
- competent team members equipped with the skills necessary for delivering the team's objectives
- unified team commitment, with clear supremacy of the team goal over individual goals
- a collaborative climate with significant levels of mutual trust
- clear and demanding standards for team performance
- external support and recognition
- effective team leadership.

These fundamental ingredients have frequently been missing in CMHTs, especially in their early incarnations, resulting in staff burn-out and low morale: 'CMHTs were

characterised by conflicting philosophies and work practices and led by inexperienced managers, operating within organisations often faced with competing and contradictory policy demands' (Simpson *et al* 2003, p 500).

Another issue that community mental health teams struggled with was deciding who should be the core focus of their attention. Although CMHTs were established to support those with acute mental illness who were at risk of hospitalisation, cases of much more minor mental health problems were frequently referred to them, leaving them struggling to cope with their acute workload (Onyett *et al* 1994).

The CPA, too, started trying to encompass everyone referred to specialist services, but has since moved to focus on those who have a wide range of needs from a number of services, and/or are most at risk (Department of Health 2008d). With more than 15 million people with long-term conditions who could potentially require a care plan, there might very well need to be a rethink about who would benefit most from a more structured approach.

Lessons from other models of integrated care

This section takes a brief look at the experience of other examples of integrated care. It draws on a review of the evidence on the integration of health care and delivery systems by Mowlam and Fulop (2005), looks at some of the research on care trusts and the development of primary care teams in the United Kingdom, and considers the development of a range of integrated care models in the United States.

Mowlam and Fulop stress the importance of focusing on process as much as on structure when integrating services: 'Implementation of any type of integration requires detailed projection and planning, not only of the organisational structure, but also in terms of the processes relating to the care being delivered' (Mowlam and Fulop 2005, p 32).

In a recent review of integrated health care systems in the United States, Gleave (2009) notes that the successful models have always been built on strong clinical leadership and robust management processes, combined with a supportive culture.

Mowlam and Fulop also underline the importance of managing those affected by the integration effectively, as different professional groups will have different cultures and perspectives that could conflict and undermine the potential benefit of organisational integration.

This finding resonates with that of Freeman and Peck in their 2007 review of the experience of care trusts: '…the weight of evidence suggests that care trusts work only where there is existing good relations between sectors; where existing inter-agency relations are not good, the organisational and cultural challenges involved in organisational merger risk making relations worse' (Freeman and Peck 2007, p 24)

In 1992, the Audit Commission identified the same problems and issues for primary health care teams.

> *Separate lines of control, different payment systems leading to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status, all play a part in limiting the potential of multi-professional, multi-agency team work. These undercurrents often lead to rigidity within teams, with members adhering to narrow definitions of their roles, preventing the creative and flexible responses required to meet the variety of human need presented. They are also likely to lower morale.*
>
> (Audit Commission 1992, p 20)

One care trust that has delivered successful outcomes is Torbay, which won the *Health Service Journal* Managing Long-Term Care Award in 2008 for its model of teamworking (*see* box below).

Integrated teams in Torbay: *Health Service Journal* Awards 2008 case study

Five integrated frontline teams made up of district nurses, social workers, occupational therapists and physiotherapists work to support a group of general practices providing health and social care services at Torbay Care Trust.

Each team has a single point of contact, staffed by health and social care co-ordinators. These experienced support staff take referrals from GPs, professionals, patients and carers, and can often sort out a problem immediately. They also co-ordinate the care of the trust's most complex patients.

Launched in 2005, the health and social care co-ordinators contribute to holistic needs-led assessments and provide short-term management of caseloads of varying complexity.

This ensures the monitoring, delivery and review of care packages that comply with all statutory and trust requirements, including the newly adopted Kaiser model approach.

With the ability to order simple pieces of equipment, organise meals on wheels or arrange a temporary nursing home placement, the co-ordinators provide a seamless service and invaluable continuity of care.

The care co-ordinators are considered the axis around which activity in each team revolves. Patients, carers and staff report how valuable the care co-ordinators are, and their presence allows people, particularly those needing end-of-life care, to be treated at home.

Torbay is working with its partners to explore how the care co-ordinator role can be expanded so as to streamline access further and improve response times.

Source: www.hsj.co.uk/insideknowledge/hsjawards2008/2008/12/managing_long_term_care_supported_by_sanofi_aventis.html

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The success in Torbay has been ascribed to a range of factors (Colclough 2008) including:

- strong local leadership
- a values-based approach
- heavy investment in organisational development
- a previous history of good working relations.

A successful model of fully integrated care for older people in the United States is the Programme for All-Inclusive Care for the Elderly (PACE). This programme provides the full spectrum of health care services, from primary to acute to long-term care for frail elderly individuals certified to require nursing home provision. Mukamel *et al* (2007) evaluated the programme and identified some characteristics that were associated with better functional outcomes. These included:

- the planning and delivery of care by high-performance multidisciplinary teams
- significant input to those teams from primary care physicians
- access to a broad range of services in a day care setting.

However, Mukamel *et al* (2007) noted that it has been very difficult for other providers to replicate these elements.

A good summary of how the elements identified above can be combined to deliver high-quality care is provided by Tollen (2008). She describes how organisational attributes such as scale, cohesion and affiliation, can contribute to processes such as the use of evidence-based medicine and care management protocols, as well as the use of health information technology, to drive improvements in quality and patient outcomes.

Finally, the findings of Dixon *et al* (2004) are worth noting. When reviewing models of integrated care in the United States, they found that competition can act as an impetus to improvement: 'Overall, we were convinced that the incentives arising from market pressures on the managed care organisations (within limits) contributed to the quality of service and the focus on the needs of their members' (Dixon *et al* 2004, p 224).

Community health services have hitherto not been subject to any form of competition or contestability.

Conclusions

The experience of integrated care models, including the introduction of community mental health teams and the CPA, suggests that if primary care trusts wish to deliver more patient-focused and integrated care through their new community services structures, they need to:

- focus on process as much as on structure

- pay attention to the human and cultural dimension of change including ensuring that:
  – the key enablers of effective teamworking are in place
  – there is a widely understood set of values and principles to underpin the new ways of working
  – there is clarity about the patient group and needs being served

- ensure significant input from primary care physicians

- recognise that contestability can act as an impetus to service improvement.

8 What are primary care trusts doing now?

Feedback from participants at the expert seminar and a review of a stratified sample of 22 primary care trusts (PCTs) suggest that the latter are using a variety of approaches to developing their community services.

- Some PCTs are taking time to explore the strategic issues associated with their current portfolio of services, while others are more focused on organisational solutions.

- Some are seeking 'hard' separation and the complete transfer of community health services to other organisations, while others are pursuing a 'softer' separation that maintains services in the same organisation but with arm's length governance.

- Some PCTs are considering opening all their services up to competition, while some are taking a more targeted approach, focusing on the services that are working the least effectively.

- Of the 152 PCTs in England, only a handful are currently working towards community foundation trust status.

The rate at which change is happening is also varied. Some have only just created clear governance distinctions within their current structures, while others are well on their way to creating separate organisations.

For many PCTs, this appears to have been the first time they have truly understood and mapped out their current service portfolio, revealing wide variations and anachronisms. South Birmingham PCT, one of those aspiring to community foundation trust status and now in the development group for Developing High Quality Community Services said in a recent board report: 'The review [of community services] found that there has not been a clear commissioning approach to service development in the past, with development characterised by *ad hoc* planning' (McGrath 2007, p 2).

This echoes a report by Deloitte (2008), which found that a major challenge for the aspirant community foundation trusts was the lack of a clear commissioning strategy.

Weak commissioning was also picked up as an issue at the expert seminar. One participant said: 'We have had eight commissioners, including a brand-new PCT… None of them are commissioning for outcomes, but you need to define outcomes to really get productivity gains.'

9 What are the future service configuration options?

This section looks at the future service configuration options. It does not reflect on the various governance options, which have been fully explored by the Health Services Management Centre (HSMC) in Birmingham working with the national law firm Hempsons (Smith *et al* 2006). Their report provides a thorough analysis of the different models of organisation and governance (legal entities) that could be adopted by primary care trusts for their provider services. They assess the benefits and risks of six NHS-based models, including a variety of integrated models, and five non-NHS bodies, including social enterprise models. Appendix C (*see* pp 38–39) gives a summary.

This report assesses the degree to which some of the different integration options support the strategic aspirations for community health services, using five criteria to judge an organisation's fitness for delivering effective community health care (*see* Table 3 overleaf). This analysis builds on an earlier one developed by Hadfield (1997) but adapted to the current policy context. In common with the HSMC analysis of governance options, the assessment shows that each option has strengths as well as weaknesses: there is no perfect solution. This also resonates with the earlier lessons from history and other evidence on integrated care. It is not the organisational structure that delivers the service benefits, but the leadership and processes that sit within it.

The analysis also demonstrates that strong outcome-based commissioning with a focus on pathways of care across networks of providers can mitigate some of the inherent weaknesses in all the different potential models.

The NHS Alliance has proposed the formation of integrated care organisations (ICO) covering a geographical area built on practice-based commissioning clusters (PBC, *see* Figure 5, p 25), 'which would mean ICOs were firmly located in primary care' (NHS Alliance 2008, p 15). However, the NHS Alliance also recognises that 'PBC would require a level of maturity, inclusiveness and sophisticated incentives'. The evidence suggests this is not yet present (Curry *et al* 2008).

The SeeSaw project, a recent simulation-based exercise commissioned by the Department of Health's Shifting Care Closer to Home policy team and led by The King's Fund in partnership with Loop2, found: 'The integration of community health services and practice-based commissioning appeared to make intuitive sense and both parties found lots of opportunities to work together. However, the governance arrangements and nature of the partnership proved a more significant challenge' (Harvey and McMahon 2008, p 50).

Table 3 Relative strengths of different integration options

	Stand alone community trust	Combined community and primary care	Combined community and social care	Combined community and acute care
Capable of developing professional standards, both in line with the evidence of effective outcomes, and also with the needs and preferences of individuals (Meeting professional and client group needs)	Can provide a critical mass of professionals, and there are examples of good practice Structural divide from GPs dilutes feedback loop from users	Good history of audit now underpinned by QOF Concerns around variation in quality between different practices, and whether current primary care structures are robust enough to develop a wider range of clinical standards	History of individual care planning and designing services around needs of users Social care is focused around commissioning rather than provision, so may be weak in supporting professionals in standards development	Can provide a critical mass of professionals, and there are examples of good practice Structural divide from GPs dilutes feedback loop from users Risk that practice is disease-focused rather than user-focused
How could commissioners mitigate?	The lack of an evidence base is a generic challenge for community health services (Manning and Setchell 2007) By focusing on individual outcomes, including user experience, commissioners can drive improvement and help develop evidence-based practice			
Capable of being part of a wider health care network (Supporting locality)	Previous experience suggests that this will vary widely and depend on the organisational culture	The experience of practice-based 'providing' suggests that there is a risk of increased separation, although this will vary	The experience of mental health trusts suggests that there is a risk of isolation from mainstream services, although this will vary	Previous experience of combined acute and community trusts does not suggest particular advantage
How could commissioners mitigate?	Contracting with networks of providers to drive a more integrated approach			
Capable of planning and implementing strategies for key resources, ie, human, financial, buildings, equipment/ supplies and IT	The relatively smaller scale and lack of access to capital has resulted in a lack of investment in estate, IT and workforce development	General practice has historically had little experience of strategic management of key resources, but practice-based commissioning is changing this	The shift within social care to commissioning rather than provision may have weakened this capacity	NHS trusts are expected to have the necessary strategic capability, but this varies from organisation to organisation
How could commissioners mitigate?	Encourage partnerships that create the necessary critical mass and expertise; LIFT and the local LIFTCo would be an example of this			
Capable of motivating the workforce (Professional needs)	Could develop strong morale and ethos depending on the organisational framework and strength of leadership; Central Surrey Health provides an example as a social enterprise	Experience of devolving staff into primary care has had mixed success Non-medical staff can feel less valued Primary care organisations do not tend to have strong organisational capacity	Likely to depend on strength of local leadership Could generate enthusiasm from increased capacity to offer better integrated packages of care	Previous experience would suggest that there is a risk of community services being perceived as 'Cinderella' or support services to the acute function
How could commissioners mitigate?	Highly dependent on individual leadership capacity Difficult to address from a commissioner perspective			
Value for public money by minimising expenditure on overhead or transaction costs	There is a tendency to be inefficient There are particular challenges in managing a largely peripatetic workforce	Historically there has been a strong value-for-money-focus given the nature of the primary care contract This is now strengthened by practice-based commissioning developments	Joint services provide opportunities to share overheads and avoid duplication	Joint services provide opportunities to share overheads, and joint budgetary arrangements could mitigate the perverse incentives created by the current tariff
How could commissioners mitigate?	The introduction of community tariffs should drive some efficiency There is a risk of creating perverse incentives that reduce value for money overall			

GPs, general practitioners; QOF, Quality and Outcomes Framework; IT, information technology;
NHS, National Health Service; LIFT, Local Improvement Finance Trust; LIFTCo, LIFT Company

Figure 5 Integrated care organisations
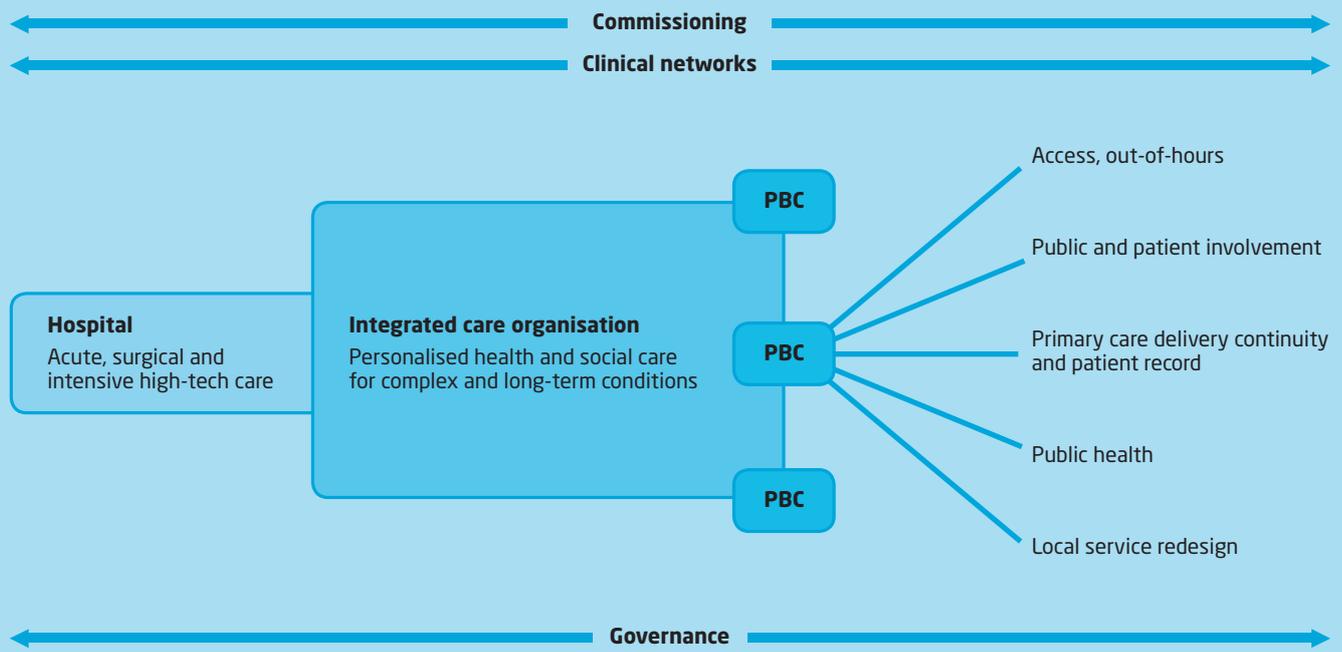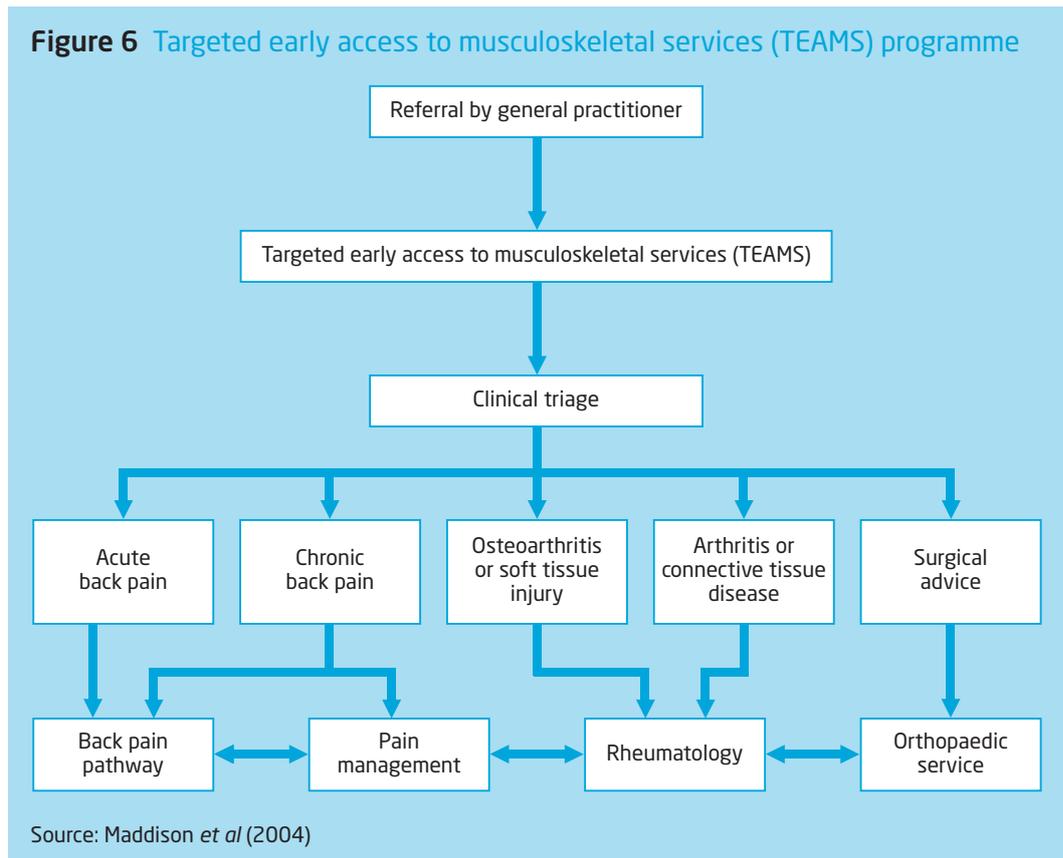

Source: NHS Alliance (2008, p 13)

'Virtual' integration

Community health services interface with all parts of the health care system. To align them formally with one part could create problems because of the distance it creates from other parts. An alternative to pursuing formal organisational integration, and the tensions and trade-offs that this creates, would be to support integration through clinical networks and defined patient pathways. In their international review of different models of integration, Ham *et al* (2008) highlighted integration through 'care co-ordination', although clearly it carries the risk of stasis, as underlined by the NHS Alliance (2008).

The SeeSaw simulation also suggested that the extended care pathways involved in providing care closer to home were likely to drive providers to work together in a more virtually integrated way, with supply chains that would include social and domiciliary care providers (Harvey and McMahon 2008).

The Queen's Nursing Institute supports a virtually integrated model in its vision for the future of district nursing (Cook 2006). It proposes 'virtual teams' of both health and social services staff working from 'referral hubs'. Each hub would provide a unified point of access for single assessments, and also sift, assess and allocate new contacts to ensure that patients were seen by the most appropriate professional. This approach could also offer opportunities for better integration of primary care-based nurses and community nurses. As practice-based nurses extend and develop their roles, there is the increasing likelihood of duplication and overlap with community nursing roles. This model is not dissimilar to that developed in Torbay.

The new models of care developed for musculoskeletal services provide an example of the feasibility of a more integrated approach across organisational boundaries. One of many examples is described by Maddison *et al* (2004). In North Wales, a multidisciplinary team was set up with professionals employed by primary, community and secondary care with a single point of entry (*see* Figure 6 overleaf). The pathway allows a more personalised response to patients, and has resulted in a significant fall in waiting times.

Figure 6 Targeted early access to musculoskeletal services (TEAMS) programme

Referral by general practitioner

Targeted early access to musculoskeletal services (TEAMS)

Clinical triage

| Acute back pain | Chronic back pain | Osteoarthritis or soft tissue injury | Arthritis or connective tissue disease | Surgical advice |

| Back pain pathway | Pain management | Rheumatology | Orthopaedic service |

Source: Maddison *et al* (2004)

This model could align well with the more federated approach to primary care suggested by the Royal College of General Practitioners (Field *et al* 2008).

It is also important to bear in mind the points made earlier in this report about the lack of strategic synergy within the portfolios of many community providers. At the expert seminar, the point was made that different organisational forms could be suited to different staff groups and services: 'A community nurse might want to be part of a social enterprise, while a physiotherapist might want something different', in the words of one participant.

Issues of choice and contestability also arise. Some elements of community services might be best organised geographically, such as the integrated health and social care teams that operate in Torbay (*see* p 20), while others might be subject to a greater degree of contestability. There are also opportunities to 'micro-commission' some services through community teams, or via individual budgets.

Conclusions

A high-level review of the options for the configuration of services in the future demonstrates that there is no single 'right' answer. Any option will require new ways of working if it is to deliver more effective and co-ordinated care. Different solutions will suit different local circumstances and different services. Given the challenges of merging organisations, the 'virtual integration' approach might be an easier first step for some services.

Whichever option is chosen, there will need to be strong and clear-sighted commissioning founded on well-defined outcome-based criteria, which should drive the pattern of service provision. Partnerships with the private sector or social enterprise models could provide opportunities to encourage innovation and improve motivation and performance.

10 Recommendations and conclusion

The imperative to map out a future for primary care trust (PCT) provider services gives PCTs the opportunity to realign their local health care system to address the needs of some of the most vulnerable in their population, particularly those with long-term or disabling conditions. It should provide the stimulus to make good the years of inattention and underinvestment in community health services. As one participant at the expert seminar said: 'In terms of an opportunity to do good, this is a huge opportunity.'

Key recommendations

This review of the issues facing services today, the experience of previous attempts to reorganise community health services, along with previous attempts to integrate health services including mental health services, offer some clear messages about the areas that require PCT attention if the much-needed service transformation is to be achieved. These include the following.

Learn the lessons from history

- Simply redrawing organisational boundaries will not alone deliver the change required.

- Strong leadership at national and local level is necessary to deliver change.

- The links with primary care are critical, and need to be strengthened as part of any solution; the primary care consortia emerging out of practice-based commissioning offer new opportunities to forge and strengthen these links.

Draw on the evidence offered by successful models of integrated care

- Focus on process as much as on structure.

- Pay attention to the human and cultural dimension of change, including ensuring that:
  – there is a widely understood set of values and principles to underpin the new ways of working
  – there is clarity about the patient group and needs being served
  – the key enablers for effective teamworking are in place.

- Ensure significant input from general practitioners (GPs).

- Contestability can act as an impetus to service improvement.

Improve performance and productivity

- Clarify referral pathways for both general and specialist services.

- Clarify the roles and responsibilities of individuals and teams.

- Ensure there are systematic approaches to caseload management.

- Provide a service that is needs-led rather than demand-led, for example by using case-finding tools.

- If some community services are to provide a genuine alternative to hospital care, they need to be able provide round-the-clock support (24/7), with close working between all those offering support in the out-of-hours period.

Service portfolio, resources and infrastructure

- When considering the future of services, group together those that offer strategic coherence.

- Review the community estate, and ensure that it supports the desired model of care in terms of a high-quality therapeutic environment.

- Ensure staff have the technological support necessary to improve productivity and overcome the barriers between primary, secondary and social care.

- Ensure workforce plans take account of a growing and ageing population, along with loss of staff due to retirement.

Specific recommendations for PCTs as commissioners

In future, strong commissioning will be as important as strong provision. The recent Department of Health guidance (Department of Health 2009) has been accompanied by a host of resources for commissioners, including good practice examples, model contracts, and quality and pricing frameworks. These offer good practical support to PCTs in their roles as commissioners of community health services. In addition, the National Health Service (NHS) Institute for Innovation and Improvement is about to publish guidance that will help PCTs to commission for best practice and drive productivity improvements (NHS Institute for Innovation and Improvement 2009).

In the light of the findings of the research for this report, the authors would also draw the attention of PCTs to the following points.

- The use of outcome measures and contracting with networks of providers for more integrated models of care can help to overcome inherent weaknesses in any organisational solution.

- Use of the world class commissioning cycle will provide a good needs-led basis to take services forward. There are particular opportunities here to engage staff and patients in designing local solutions. While their views will be valuable in the monitoring and evaluation stage, they will be equally important for needs-assessment and when designing services.

- An important element will be to review the balance of resources across primary, community and acute care. PCTs may usefully benchmark themselves here against peers. There might well be a case for rebalancing resources between the three sectors.

- As far as possible, PCTs need to build flexibility into any solution to allow it to adapt to changing client needs and likely changes in the organisational environment. Any solution should strengthen the links and co-ordination between primary and community care services. PCTs should exploit the opportunities to link the strategic development of practice-based commissioning to the new models of community care.

- It may be necessary to map a transition path over a period of several years in order to develop the necessary strategic clarity and organisational capacity within the new provider organisations.

- Any model pursued should be formally evaluated. The experience gained from the developments in community mental health showed that there was inadequate evaluation of the new models of care, which limited the successful development of this new way of working (Simpson *et al* 2003).

- Finally, PCTs need to ensure core workforce and infrastructure issues are addressed. Workforce plans need to consider future workforce deficits, as well as support training for any newly developed roles and any staff moving from an acute hospital to a community setting.

Recommendations for community providers

Community health service providers need to create a strong organisational and governance model and strategic coherence for services in the future. A clear vision and set of values will be an important binding and mobilising force for staff.

The service portfolios that many provider arms will inherit will lack strategic coherence, and different service elements might benefit from different organisational solutions.

Any solution needs to address local service weaknesses. Providers need to ensure that there are clear referral criteria and routes, with single points of contact where possible. Providers will need to strengthen links and co-ordination with other elements of the health and social care system. They need to capitalise on their roles as bridge-builders and forces for integration. Strong capabilities in care planning will facilitate this.

Community providers will also benefit from the guidance on best practice from the NHS Institute for Innovation and Improvement. It will give very helpful guidance on some of the techniques and methodologies that produce the best patient outcomes, particularly for continence, stroke and wound care (NHS Institute for Innovation and Improvement 2009).

National issues

The Department of Health has initiated a wide-ranging programme to strengthen community health services. Entitled *Transforming Community Services: Enabling new patterns of provision* (Department of Health 2009), a key message from this work, however, is that change at the level required cannot be driven centrally. This does not mean that there is no role for the centre, but that the limitations of the national role need to be recognised.

Some participants at The King's Fund expert seminar were also concerned about the rate at which change is expected to happen. The experience of one organisation taking on a new organisational form was that it had taken 18 months just to 'get going on the ground' and deal with basic issues such as pay and pensions. The participant added: 'One of the things about community foundation trusts is that everybody seems to think that getting through [the] Monitor assessment [process] will take three years from where we are… So why should it be quicker with any other organisational form?'

Change is going to take time. The Department of Health should not force change at a pace that will undermine successful outcomes.

Areas that will require national support are:

- raising the profile of community services so as to ensure that they are a major focus of the world class commissioning agenda and not seen as subsidiary to it

- work on the community tariff and relevant outcome measures, including patient-reported outcome measures

- encouraging local and national evaluations of the new models of care.

Conclusion

Given the other demands created by the world class commissioning agenda, there is a risk that PCTs will focus on delivering new organisational models and miss a critical opportunity to modernise and improve services. Lessons from previous reorganisations tell us that new organisational structures will not of themselves deliver benefits, and could present risks if cultural and workforce issues are not addressed. Benefits arise from the core values, leadership and processes that underpin any new structure.

Of course, this should not be seen as a reason for retaining the status quo: change is needed more than ever, and the current drive for reform provides a real opportunity to map out a new, more focused, future for community services. It should also give PCTs the opportunity to concentrate on commissioning high-quality care that is based on good evidence of what works and provides good value for money.

Summary of key points made at expert seminar

What are primary care trusts doing now?

A wide variety of approaches was described for different primary care trusts (PCTs) known to participants:

- a 'managed dispersal' of provider functions
- exploring the social enterprise route
- arm's length separation only
- reviewing all services to see whether they are fit for purpose and then considering market testing those that are not
- pursuing the community foundation trust route
- adopting a holding position.

Debate

Full organisational separation or not?

Some participants felt strongly that PCTs could not focus on the demands of the world class commissioning agenda 'if you are worrying about nursing rosters', and so argued for full organisational separation. Others felt equally that a total separation of the two functions would lessen PCTs' appreciation of local health needs and threaten PCTs' capacity to address agendas such as health inequalities.

Form over function?

There was concern that amid all the discussion of organisational forms, the purpose of the latest round of changes to community health services could be lost.

> *Some of this seems to be driven by 'we need to separate' without a sense of why, and that is where I get worried.*

> *We need to get over the variation in quality, and that has hardly been touched on. We have lots of graphs showing we are getting a bad return for taxpayers and that clinical outcomes vary. That is what this should be about. I want this to be about community needs. I am really worried about people going straight to structure. [If that happened] this will just be another management restructuring.*

> *We could have had a conversation about how to get services working better, but that is not the conversation we are having.*

On the other hand, some argued thus:

> *…sometimes we need form to get function.*

> *I think that starting with organisational form gives people something to get going with.*

You might need to start with organisation [so] you can change support for the people in [them] so they can do what you want them to do.

We are talking about community health services like they are one thing, when they are not… Different organisational forms might well be suited to different staff groups and services… A community nurse might want to be part of a social enterprise, while a physiotherapist might want something different.

It was important for commissioners to work with providers to see 'whether they want to be John Lewis or Wal-Mart', to see 'what business… they want to be in, so we can commission to that'.

Keeping sight of the patient

In the middle of this debate about form and function, some members of the audience questioned whether other policy imperatives were being lost. In particular, they wondered how Darzi's emphasis on patients taking more control of their own health and treatment fitted in.

Really customer-focused organisations start with the customer. When people in the north-west were asked about chemotherapy services, they talked about the wig service, not chemotherapy.

At the moment, we think this is about commissioning and then consulting people in town hall meetings. We need to tip it up the other way.

One PCT described how 'now we are out the other end [of the decision to have the provider arm work towards community foundation trust status] there is a real focus on patients', adding that this would 'get bigger over time'.

Taking stock versus pushing ahead with gains made

Some made appeals for National Health Service (NHS) organisations to be allowed to 'get on with things'. One said:

We have made a good start. We do not want to slow that down by making people revisit things. We do not want to have to go back and look at world class commissioning, because we have done that.

Others echoed this with comments such as 'we should let people get on with it', 'the market will develop', and 'it is important to get focus on what matters, but separation will help with that'.

Yet others argued that a period of stability was required: 'It is really hard for people trying to make this work if policy-makers are already on to the next big thing.'

Change takes time

Some participants were concerned about the rate at which change is expected to happen. The experience of one organisation taking on a new organisational form had been that it took 18 months just to 'get going on the ground' and deal with basic issues such as pay, pensions and 'rubbish information technology'.

One of the things about community foundation trusts is that everybody seems to think that getting through [the] Monitor assessment [process] will take three years from where we are… So why should it be quicker with any other organisational form?'

Practical challenges on the ground

Governance of new provider organisations

New provider organisations need sufficient capital and other assets to maintain themselves. They must be strong enough to engage on an equal basis with their commissioners. They need good governance arrangements, including strong boards – both executive and non-executive members, with non-executives being able to exert appropriate influence and challenge. Yet they also need the flexibility to address different circumstances: 'one size is unlikely to fit all'.

Estate and information technology

Many PCTs do not want to hand assets over to new organisational structures in order to avoid asset lock-in, and yet it was difficult for organisations to be financially independent without an asset base and relatively long-term contractual commitments.

There was wide recognition of the low use of information technology (IT). One participant described a recent investment in IT that was anticipated to produce big productivity gains:

> *In the past six months, we have given everybody a laptop so they can communicate on an as-required basis and that should yield productivity gains for us.*

The community-based estate is unevenly distributed and tends to reflect history rather than need. Almost 50 per cent of community hospitals are more than 40 years old, and just over 40 per cent predate the NHS.

Community health services have traditionally underinvested in IT, either to meet business needs (which is one reason there is so little information about them) or to support clinical staff (who rarely have access to modern electronic records or unified communications technologies).

Outcomes-based commissioning

One participant commented:

> *We have had eight commissioners, including a brand-new PCT… None of them are commissioning for outcomes, but you need to define outcomes to really get productivity gains. You also need to measure those; and without IT you cannot do it.*

Workforce

Comments included:

> *We know that services need to move into the community to deliver Darzi, but that means training, and it means addressing some cultural issues.*

> *Traditionally, young people have worked in hospital and then moved into the community later in their careers, so we might want a different postgraduate career path – and we will need to use pay to incentivise.*

Conclusions

> *With £10 billion being spent on them, and more than 250,000 staff working for them, community health services should receive far more attention than they [do].*

> *In terms of opportunity to do good, this is a huge opportunity… [which] will only rise as the population ages and the burden of chronic disease rises.*

Participants agreed that there is 'a lot to be done' to make sure the opportunity was realised in areas such as moving towards a more contestable marketplace with strong providers, and commissioning for outcomes.

However, I think the key question is what we can do over the next couple of years, as we progress this agenda, to show value… I think we need to show benefit on the ground, so we have something to show people that says this is worth it.

We also need to pick some areas of service to improve, and decide what good looks like, and how to get it.

The key to escaping community health services' history of constant reorganisation is to recognise that 'this cannot be done from the top-down'.

Whatever form new provider organisations take, they somehow need to remain flexible enough to respond to changing demands:

Building flexibility into organisations is difficult, because organisations want to be successful.

If success means not looking like they do now in three years' time, that is hard to achieve.

Participants felt that the key to success was to focus on people:

…both the people you are dealing with, and the people dealing with them.

I think confidence and profile-building for staff is vital, and that the culture change cannot be underestimated.

We have talked about form and function, but there is another 'f': feeling. Instead of focusing on changing organisations, people needed to focus on changing the feeling of the people working in them.

Participants at the Shaping PCT Provider Services Seminar, 6 November 2008

Name	Job title	Organisation
Oliver Bernath	Managing Director	Integrated Health Partners Ltd
Howard Catton	Head of Policy Development and Implementation	Royal College of Nursing
Ian Church	Chair	Central Surrey Health
James Close	Partner	Ernst & Young
David Colin-Thome	National Clinical Director for Primary Care	Department of Health
Rosemary Cook	Director	The Queen's Nursing Institute
Sarah Crowther	Chief Executive	Harrow PCT
Angela Dawe	Director of Primary Care and Community Services	Lambeth PCT
Anna Dixon	Director of Policy	The King's Fund
Michael Dixon	Chairman	NHS Alliance

Name	Job title	Organisation
Michelle Dixon	Director of Communications	The King's Fund
Andrew Donald	Chief Operating Officer	Birmingham East and North PCT
Stephen Dunn	Director of Strategy	East of England Strategic Health Authority
Penny Emerit	Head of Implementation, Polyclinics Team	Healthcare for London
David Evans	Principal Policy and Performance Officer, Strategy	London Borough of Hammersmith and Fulham
Helen Fentimen	Policy Advisor	Department of Health
Robert Ferris	Chief Operating Officer	Peterborough Community Services, NHS Peterborough
Dan Fletcher	Head of Partnerships and Fundraising	The King's Fund
Joe Gannon	Chair	Westminster PCT
Alan Gavurin	Major Projects Director	Assura Group Ltd
Nick Goodwin	Senior Policy Fellow	The King's Fund
Gary Howe	Partner	Ernst & Young
Candace Imison	Senior Policy Fellow	The King's Fund
Richard Lewis	Director – Healthcare	Ernst & Young
Alasdair Liddell	Senior Associate	The King's Fund
Adrian Masters	Director of Strategy	Monitor
Trisha McGregor	Joint Chief Executive Officer	Central Surrey Health
Helen Parker	Co-director	Health Services Management Centre, University of Birmingham
Alpesh Patel	Partner and Head of Health Practice	Ernst & Young
Jo Pritchard	Joint Chief Executive Officer	Central Surrey Health
Anne Reeder	Programme Manager	Peterborough Community Services, NHS Peterborough
Bob Ricketts	Director of System Management and New Enterprise	Department of Health
Clare Steward	Performance Manager, Provider Development	East of England Strategic Health Authority
David Stout	Director – Primary Trust Care Network	The NHS Confederation
Rita Symons	Director of Strategy and Commissioning	South Birmingham PCT
Adam Thynne	Director – Transaction Services	Department of Health

Breakdown of NHS staff

Figure B1 Breakdown of NHS clinical staff by organisational type, 2007 (full-time equivalents)
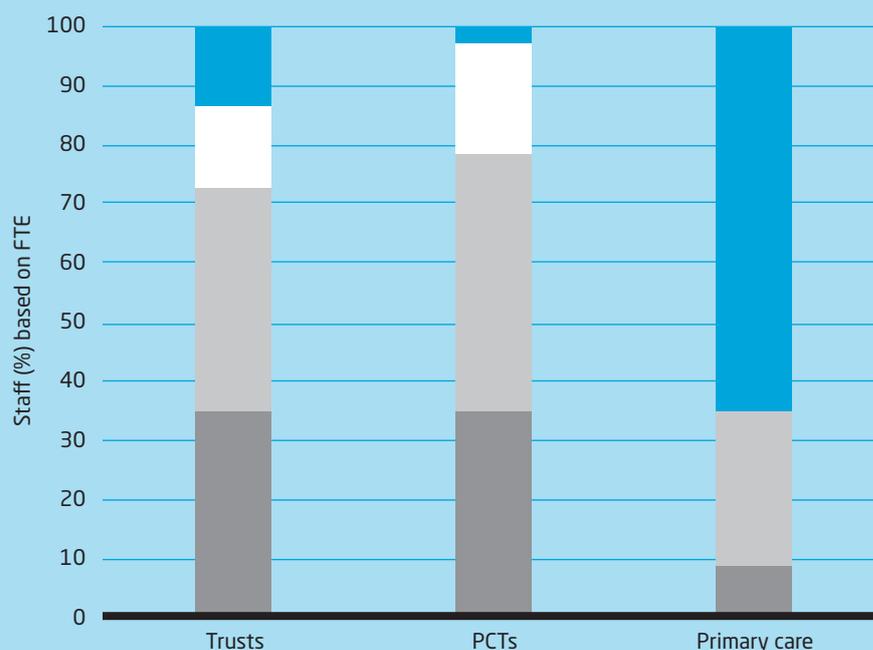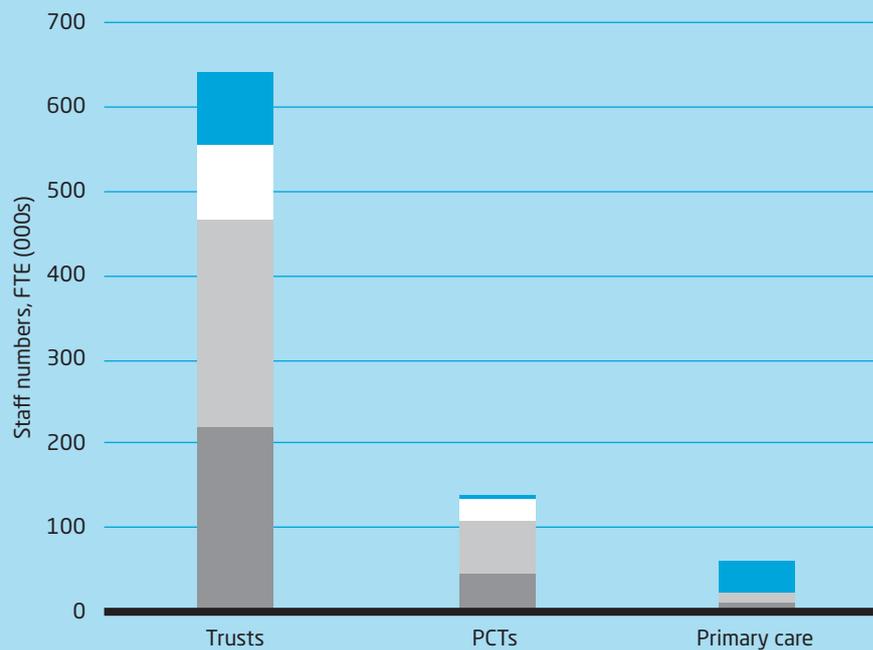
Medical

Scientific, therapeutic and technical

Nursing

Support to clinical staff

FTE: full-time equivalent

Source: NHS Information Centre for Health and Social Welfare (2007)

Figure B2 Breakdown of PCT clinical staff into different professional groups, 2007 (full-time equivalents)

FTE: full-time equivalent

Source: NHS Information Centre for Health and Social Welfare (2007)
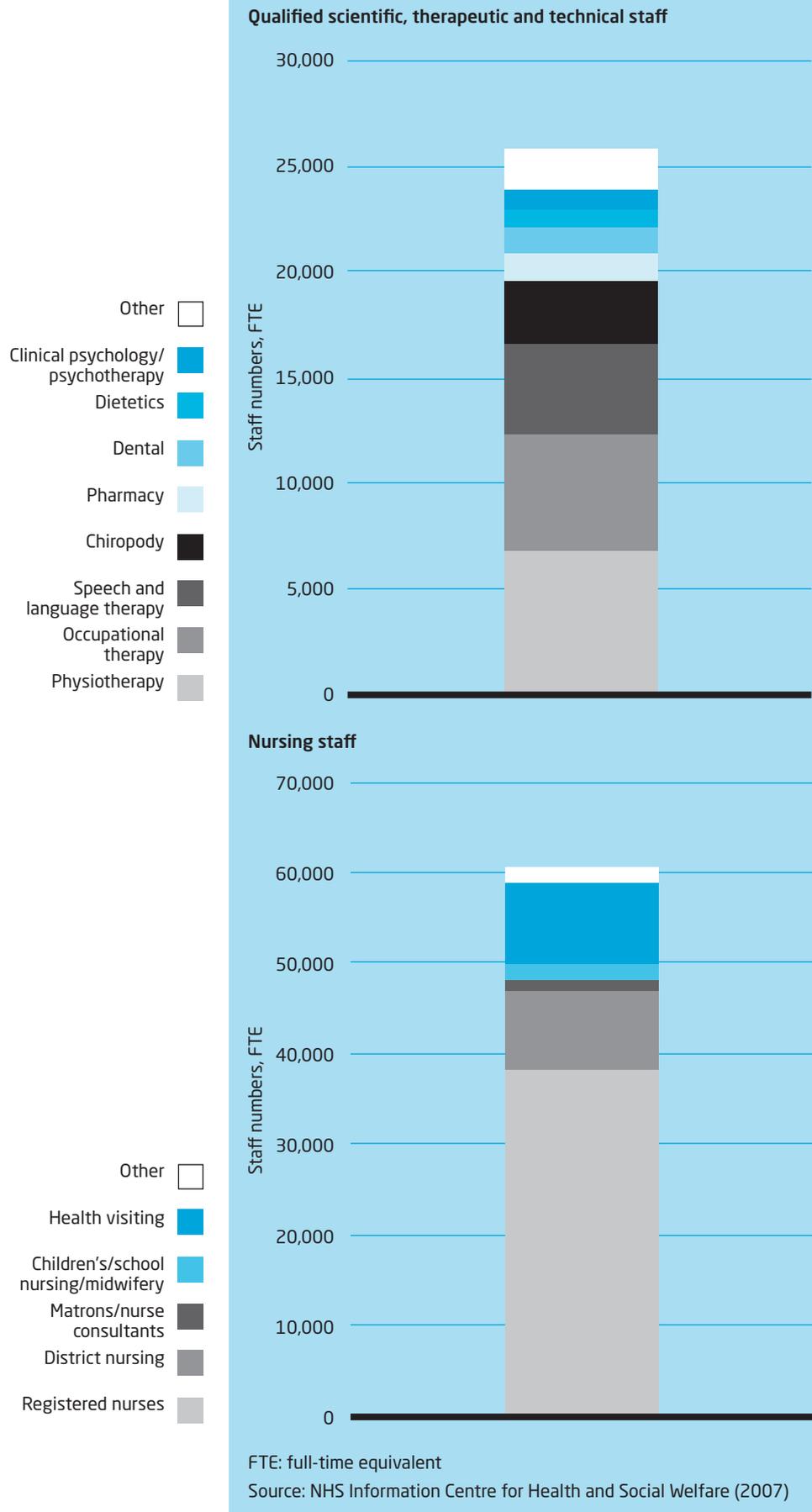
Analysis of the options for primary care trust provider services

Table C1 Options for primary care trust provider services: benefits and risks

NHS family		
Organisational form	**Benefit**	**Risk**
Managed practitioner network	■ Patient-focused ■ Might be more readily realised as a functional rather than a structural solution ■ Likely to be no procurement constraints as it is in-house	■ No external drivers or challenge in relation to excellence ■ Potential for service fragmentation as the focus is on the clinical condition, not the whole patient ■ Falls down for patients with multiple needs ■ A piecemeal solution only ■ Integration between health and social care could present challenges and some regulatory issues
Horizontal integration (children's trust, care trust)	■ Integration across organisational boundaries can preserve existing staff benefits, although secondment models have been called into question ■ Established and flexible model suitable for a large number of different applications/situations	■ Frictions from two-system approach (health and social services) ■ Potential ambiguities over extent of responsibilities ■ Constitutionally complex in practice
Vertical integration of acute and primary care	■ Whole care pathway solution ■ Financial incentives towards system efficiencies	■ Potential for monopoly provider ■ Largely untested in the UK ■ Requires an accountability framework to be developed with the commissioning PCT ■ Structural difficulties could be avoided by virtual integration
Provider unit	■ Provides continuity and stability ■ Removes need for consultation on forming a new body ■ Avoids the contractual, employment, pensions, equipment and property issues associated with forming a new body ■ Allows informal and ad hoc arrangements ■ Maintains provider function access to PCT support services ■ Maintains NHS assets and goodwill in public ownership ■ Safeguards services for vulnerable groups that might not be best served by independent providers	■ A service-level agreement imposed by the PCT as commissioner would have no legal enforceability (PCT cannot contract with itself) ■ Unless leadership of the provider function had no links with the commissioning arm, the provider arm could not claim to be an independent body ■ Might be difficult to identify and segregate costs that are unique to the provider function ■ Legally, the provider function is indistinguishable from the PCT and therefore the PCT remains liable for its actions
Community foundation trust (public benefit corporations)	■ Existing legal form with separate legal entity (public benefit corporation) ■ Lock on public assets would be in place ■ Regulation by Monitor ensures financial rigour	■ Complex public engagement model at constitution ■ Regulation by Monitor restricts freedoms ■ Potential for monopoly provider and restricted patient choice
Arm's length management organisation (ALMO)	■ Would provide a focused delivery body ■ Would retain ownership and control ■ Might retain pension entitlements for NHS staff	■ Unlikely to be legally possible at present because of restrictions on creating separate legal entities to provide statutory functions ■ Could be possible if object was to generate 'profit' for the PCT, but that is unlikely to be a viable service model ■ If in-house, procurement with third parties would be governed by EU procurement rules ■ If not in-house, PCT would have to contract with ALMO as an external body, and the relationship could be exposed to competition

NHS, National Health Service; PCT, primary care trust; EU, European Union;
APMS, Alternative Provider Medical Services; SPMS, Specialist Provider Medical Services

Table C1 Options for primary care trust provider services: benefits and risks *continued*

Non-NHS bodies		
Organisational form	**Benefit**	**Risk**
Company limited by guarantee	■ Well known, established and flexible model ■ Suitable for not-for-profit and charitable models ■ May achieve direction status for transferring NHS staff pensions ■ Transparent legal form ■ Limited liability for members ■ Can drop limited designation in some circumstances ■ Can be a members model, with staff engaged as members ■ Separate legal entity	■ Reporting and regulatory requirements are potentially onerous ■ No NHS pension body status currently ■ No incentive to excel for personal profit ■ Will need an accountability framework to be developed with the commissioning PCT ■ Regulation by the Charity Commission if charitable status is accorded
Company limited by shares	■ Well known, established and flexible model ■ Limited liability for shareholders ■ Incentive for generating efficiencies and innovation for personal profit ■ Can be a members model, with staff engaged as shareholders ■ Able to raise equity as well as debt finance ■ Separate legal entity	■ Not a social enterprise model ■ Suspicion of for-profit models in health sector ■ Might be able to access NHS pension entitlements if structured as an APMS/SPMS provider with clinician-only shareholders ■ Needs an accountability framework to be developed with commissioning PCT
Company interest company (CIC)	■ Social enterprise objectives hardwired into constitution, eg, asset lock ■ Monitored by a regulator to ensure community interest test is satisfied ■ Limited liability for members ■ Will be recognised publicly as a social enterprise model ■ Could be direction status employer for NHS staff in relation to pensions transfer ■ Could be more acceptable to NHS staff ■ There is less need for an accountability agreement ■ Can opt for not-for-profit and for-profit models ■ Separate legal entity	■ Largely untested model ■ Constitutional constraints on action ■ Cannot be a charity ■ Not an NHS pension body at present ■ Potentially more complex regulation than some other models ■ Therefore potentially less flexible ■ Might be less able to raise finance than some other corporate forms ■ Can be for-profit ■ Questions about provision of core public services
Industrial and provident society (community benefit society)	■ Limited liability ■ Social enterprise run for the benefit of the community rather than the members ■ Capable of having charitable status ■ Could achieve direction status for NHS transferring staff pensions ■ Separate legal entity	■ Less flexible than some other corporate forms as constitutionally can be changed only with Financial Services Authority (FSA) approval ■ Cannot have open membership ■ Regulation by Charity Commission if charitable status is accorded
Industrial and provident society (co-operative)	■ Limited liability ■ Hybrid social enterprise/personal advantage model ■ Accountable, open membership policy ■ Separate legal entity	■ Will not qualify as an NHS pension provider and might not achieve direction status ■ Less flexible than some other corporate forms as the constitution can be changed only with FSA approval ■ Not capable of achieving charitable status

NHS, National Health Service; PCT, primary care trust; EU, European Union;
APMS, Alternative Provider Medical Services; SPMS, Specialist Provider Medical Services

Source: adapted from Smith *et al* (2006)

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