

# Fit for the Future

**A New Direction for Community Services in Lambeth**

## **DISCUSSION DOCUMENT**

Sue Gallagher, Chair of PCT Provider Development Committee  
Kevin Barton, Chief Executive  
Angela Dawe, Director, Primary Care and Community Services

20 August 2008

## Summary and foreword from Kevin Barton, Chief Executive

**“Our quality agenda can only succeed if the frontline NHS staff are given the freedom to use their talents.”**

**“We now need to give greater freedom to those working in community services.”**

**“We believe that staff working in community services deserve the same deal as those working in any other part of the NHS. They speak with passion about the potential for using their professional skills to transform services, but are frustrated at the historic lack of NHS focus on how to free up those talents. We will support the development of vibrant, successful provider services that systematically review quality and productivity, including new ways of working in partnership with others, to free up more time for patient care and to improve health outcomes.”**

*Extracts from High Quality Care for All, Lord Darzi's NHS Next Stage Review Final Report, July 2008, Chapter 5*

We are at a very important stage in setting the future direction of community health services in Lambeth. It is vital that we engage the staff who provide these services, and those who support them in other parts of the PCT, very strongly in the process of deciding what that future should be. We must also work closely with our local partners, and involve and listen to service users.

This paper summarises the work of Lambeth PCT's Provider Development Programme, Fit for the Future. It contains proposals for the future direction of Lambeth PCT community services in terms of what services are provided and how they are delivered. Initial ideas are also presented on possible future organisational forms.

This work will lead to a new direction and type of organisation for community services in Lambeth, so that we can fulfil the vision for community services set out in the extracts above from Lord Darzi's recent work and improve the quality of our services for the benefit of the Lambeth population. We need your involvement in deciding on what that future should be. Community service providers in PCTs across London and outside London are also going through a similar process.

We now want to have an informal discussion with all PCT staff, service users and partners about these proposals prior to issuing a formal consultation document later this year. We will also be carrying out some direct market research with service users. To take part in the discussion you are invited to:

- attend one of the lunchtime staff events on 2<sup>nd</sup>, 11<sup>th</sup> or 24<sup>th</sup> September
- come to one of the staff drop-in sessions on 6<sup>th</sup>, 13<sup>th</sup>, 16<sup>th</sup> or 17<sup>th</sup> October
- attend the GP conference on 23<sup>rd</sup> September
- attend the voluntary sector workshop on 3<sup>rd</sup> October
- fill in the feedback section at Appendix F at the back of the paper

- invite us to any event that you are organising.

Please feel free to give written comments even if you also attend one of the events. And please also complete one of the questionnaires at Appendix F to let us know what you think is most important in deciding on a future organisational form. There is one questionnaire for staff and another for service users and partner organisations. Details of where to send your feedback are in Appendix F.

Details of all the events above are in section 7, and section 5 sets out what will happen after this discussion process has finished.

For Lambeth PCT staff, section 6 gives some information about how this process will affect you.

**This is an important opportunity to take the initiative and decide together on a direction for the future which:**

- enables community services to develop to meet the needs of the people who use our services
- enables staff to have a greater ownership of their direction, their organisation and their services, and
- allows us to work closely with, and if appropriate join up with, other service providers if this benefits service users.

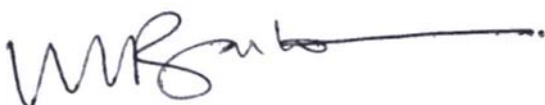
**All comments and questionnaires should be sent back by 17 October.**

Please send the feedback form and questionnaire to:

Angela Odunsi  
Lambeth PCT 1st Floor  
1 Lower Marsh  
Waterloo  
London SE1 7NT

If you would like to fill the form and questionnaire electronically please use the link on the PCT intranet or email Angela on [angela.odunsi@lambethpct.nhs.uk](mailto:angela.odunsi@lambethpct.nhs.uk).

We look forward to hearing your views.



## **Acknowledgement**

We would like to thank the Guys & St Thomas' Charity for their support in funding the market analysis workstream of Fit for the Future and the market research which is still to be completed.

## **Distribution list for comments**

- All staff in Lambeth PCT Primary Care & Community Services Directorate
- Directors of other PCT Directorates for cascade to their staff
- PCT Executive and Non-Executive Board Members
- Members of Lambeth PCT Professional Executive Committee
- Christiana Ominiya, Lambeth Staff Side Chair and all members of Staff Partnership Forum
- Susanna White, Chief Executive, Southwark PCT
- Gill Galliano, Chief Executive, Lewisham PCT
- Susanna Masters/Sarah Cottingham, Joint Directors of Commissioning in Lambeth PCT
- Donna Kinnair, Director of Commissioning, Southwark PCT
- Martin Wilkinson, Director of Commissioning, Lewisham PCT
- Lesley Humber, Director of Provision, Southwark PCT
- Jane Shepherd, Director of Provision, Lewisham PCT
- Di Caulfield-Stoker, Director of Provision, Wandsworth PCT
- Linda McQuaid, Director of Provision, Sutton and Merton
- Maggie Ioannou, Director of Provision, Croydon PCT
- Donna Jarrett, Director, Lambeth, Southwark & Lewisham Information and Communication Technology
- Debbie Carson, Director, LSL Facilities Management Services
- Malcolm Hines, Director of Finance, Southwark PCT
- Tracey Easton, Director of Finance, Lewisham PCT
- Richard Pooley, Head of Shared Services Business Unit, LSL
- Lead Partners and Practice Managers, all Lambeth GP practices
- Yashwant Patel, Chief Executive, SELDOC
- Clare Gerada, Chair of North Lambeth Practice Based Commissioning Consortium
- Malcolm Artley, Chair of GHD Lambeth Practice Based Commissioning Consortium
- Herman Lai, Chair of Lambeth Commissioning Group
- Aumran Tahir, Chair of South West Lambeth Practice Based Commissioning Consortium
- Jenny Law, Chair, Local Medical Committee
- Bob Rihal, Chair, Local Pharmacy Committee
- Peter Frost, Chair, Local Dental Committee
- Paul Thompson, Chair, Local Optometry Committee
- Ron Kerr, Chief Executive, Guys & St Thomas NHS Foundation Trust
- Jacqueline Docherty, Acting Chief Executive, Kings College Hospital NHS Foundation Trust
- Stuart Bell, Chief Executive, South London & Maudsley NHS Foundation Trust
- Peter Bradley, Chief Executive, London Ambulance Service
- Derrick Anderson, Chief Executive, London Borough of Lambeth
- Jo Cleary, Executive Director, Adult and Community Services, London Borough of Lambeth
- Phyllis Dunipace, Executive Director, Children & Young People's Services, London Borough of Lambeth
- Revd. Dr. Richard Burrige, Dean, Kings College London

- Professor Deian Hopkin, Chief Executive, London South Bank University
- Conrad Hollingsworth, Lambeth Voluntary Action Council
- Voluntary sector organisations in Lambeth
- Julia Shelley, Lambeth LINK
- Geoffrey Shepherd, Chief Executive, Guy's & St Thomas' Charity

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## 1. Context and background information

When Primary Care Trusts were set up in 2002, they brought responsibility for commissioning (ie securing high quality, appropriate health care for the population from all health care providers) and providing community health services into one organisation.

The 2005 report *Commissioning a Patient Led NHS (CPLNHS)* then raised the prospect of PCTs separating their in-house provider services. This position has been modified, but the broad policy remains to encourage separation, independence and autonomy for community provider services. The main reasons for this are to encourage innovation and service improvement, to make sure that the true costs of providing these services are understood, and to ensure open and fair awarding of contracts to provide these services.

The 2006 White Paper, *Our Health, Our Care, Our Say* reinforced two significant propositions initially set out in CPLNHS. These are:

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

Other factors influencing the move towards separation are:

- government policy to extend competition and patient choice across the NHS, including a requirement on PCTs to review their community provision in 2008/9
- moving services closer to where people live
- strengthening clinical leadership in line with “High Quality Care for All”, Lord Darzi’s NHS Next Stage Review Final Report published in July 2008
- a movement to join up services with the local authority, particularly for children’s services, in order to improve the way that services work together to support individuals and families with complex needs
- work across London PCTs to develop arms length and more autonomous community provision as a stepping stone to more independent community providers.

All of the above has prompted us to undertake a fundamental assessment of the provision of community services in Lambeth. We wanted to understand our services better, including their true costs, activity, quality, aims and outcomes, and determine how they should best develop in the future, before deciding on the right form of separation for us. These were the aims of the Fit for the Future programme.

This work will lead to a new direction and type of organisation for community services in Lambeth so that we can give greater freedom to those delivering the services and improve their quality for the benefit of the Lambeth population. This could be as a stand-alone organisation on our own or with one or more other PCT provider organisations, or by joining with another local partner. The various options are set out at section 4(c) of this paper.

This is an important opportunity for us to take the initiative and decide together on a direction for the future which:

- enables community services to develop to meet the needs of the people who use our services
- enables staff to have a greater ownership of their direction, their organisation and their services, and
- allows us to work closely with, and if appropriate join up with, other service providers if this benefits service users.

We see real benefit for people who use community health services in Lambeth from the quality improvements we can make by giving greater freedom to those who work in our community health services. This will come about through the enthusiasm and dedication of clinicians who want to use their skills to transform services to meet the needs of their patients and improve health outcomes. We want to see vibrant, successful community services which have a reputation for excellence, and which attract and keep high quality, motivated staff.

## 2. Community services as they are now

With around 500,000 contacts with patients per year through our directly managed community services, Lambeth PCT plays a leading role in the provision of healthcare services to people in Lambeth. This work is done by our 750 staff in close partnership with other service providers particularly GPs, pharmacists, our local NHS foundation trusts (Guys & St Thomas', Kings, South London and Maudsley), voluntary sector providers and Lambeth Council.

The services we provide directly are:

**Table 1: Lambeth PCT Community Services**

<b>Services provided in Lambeth (excluding support services)</b>
Children's speech and language therapy
Children's occupational therapy
Children's physiotherapy
Child health medical services (for children with disabilities, child protection, looked after children and children's audiology)
Specialist nursing for children with disabilities
Services for looked after children
Health visiting (children 0-5)
School nursing (children over 5)
Community nursing (district nursing)
Community matrons providing case management
Specialist continence service
Intermediate care beds
Continuing care beds
Supported discharge and rapid response
TACT (assessment for intermediate care)
Adult musculoskeletal physiotherapy
Adult therapies for complex and neurological conditions (physiotherapy, occupational therapy and speech & language therapy)
Reproductive and sexual health
Podiatry
Nutrition and dietetics
Acupuncture
Heart failure service
Health promotion support
Self care support
Stop smoking services
<b>Services provided across Lambeth, Southwark and Lewisham</b>
Podiatric surgery
Services for drug & alcohol users (not provided in Lewisham)
Community TB
Services for Homeless
Services for Refugee & Asylum Seekers
HIV Services
Sickle Cell Services

Other community services are currently provided to Lambeth patients by teams based in Southwark PCT or Lewisham PCT (tissue viability, home enteral nutrition, multiple sclerosis nursing, diabetes specialist nursing, immunisation support, children's home care team, children's audiology, interpreting service). There are also cross boundary arrangements with neighbouring PCTs e.g. Southwark and Wandsworth.

Angela Dawe is the designated director with responsibility for community services at the PCT. The PCT's Provider Development Committee, chaired by Sue Gallagher, has delegated authority and specific responsibility for the development and performance of PCT community services. The Committee is a sub-committee of the PCT Board and includes Dr Cathy Burton, a GP from the Professional Executive Committee. Two other Non-Executive Directors, Nicholas Campbell-Watts and the PCT Chair, Caroline Hewitt, have recently joined the Committee. The Provider Development Committee oversees and steers the Fit for the Future programme.

Commissioning and provider objectives are separately identified in the PCT Business Plan.

There is a service level agreement with the commissioning directorate of the PCT to govern the commissioning of our services. This includes service aims and outcomes, performance monitoring arrangements and regular monitoring meetings.

### **3. Summary of the Fit for the Future programme**

We started Fit for the Future in November 2007 to ensure we are fully equipped to meet the challenges of separation of commissioning and provision, an increasingly open market and a focus on quality. The programme is a fundamental analysis of local health needs and their likely progression, and also a fundamental analysis of our own services, rooted in the commissioning priorities from the Lambeth 5 year Commissioning Strategy Plan.

We have valued and appreciated the input from frontline staff and managers to this work. Through it we aim to develop a robust and viable business and transformation plan for our future, including the development of our workforce. We must also not lose sight of the underlying aim which is to radically improve services to the population of Lambeth in line with local health needs and priorities, and in particular to reduce the inequalities in healthcare provision sometimes experienced due to the high levels of deprivation in Lambeth, our highly mobile population, multiple ethnicities and other factors.

We want to base a decision about our future organisational form on a full understanding of our services and how they compare to others. We aim to get the right service model and range of services and then identify a form which is appropriate for this future direction.

## Engagement

Community services staff have been directly involved since the beginning of the Fit for the Future programme. There have been two sets of staff events organised and these have been well attended. Team Champions have been identified to act as a direct link with frontline staff. We are keen to continue participation amongst teams and to achieve two-way communication between staff and the programme through a monthly newsletter, bi-monthly service managers meetings, staff events, locality meetings, discussion at team meetings and feedback sessions.

We need to have more engagement of staff from other PCT Directorates in this discussion process, since many staff provide support services to community service provision (Quality and Professional Development, HR, IT, Finance and Estates), and we will ensure there is now closer involvement of these staff groups in the process.

We have had discussions with partners including GPs, Lambeth Council (children's and adult & older people's services), our local acute and mental health trusts and the voluntary sector. We need to continue these discussions and particularly to have more involvement of GPs in developing the ideas in this paper.

We set up a Professional Reference Group which met monthly from January to April 2008. The group consists of representatives from our services, partners (local GPs, voluntary sector, acute and mental health trusts), and patient representatives. A list of members is at Appendix A. They supported Fit for the Future by providing:

- expertise on professional issues
- broad scanning and ideas on potential future developments
- understanding of potential technological developments and their impact
- knowledge of different ways of doing things including using non-traditional staff roles
- understanding of how changes in one service could affect others
- views on the impact of new ways of working on service users and carers
- views on proposals as they emerged from the programme.

The group identified a vision for the future of our services (Appendix A) which has contributed significantly to developing our way forward.

## Audit and assessment of current services

This included an in-depth analysis of our services - activity, costs including all overheads, performance measures, clinical outcomes, clinical governance and compliance with best practice.

All services completed a template, providing quantitative information (e.g. patient contacts, clinics, patients on caseload) and qualitative information (e.g. meeting quality standards). We then analyzed activity data against service costs, with all overhead costs (e.g. rent, energy, corporate services such as HR and IT) allocated as accurately as possible, e.g. based on use of space or numbers of

staff. We did this for whole services (for example health visiting) and for the component parts of services so we could work out costs for these (eg splitting the visits to new parents from complex child protection casework).

There has been a huge amount of learning from this process and we are continuing to improve the accuracy of the information. This has helped to develop local metrics and a balanced scorecard for the community services (available on request from Dan Barnes, Senior Information Analyst, Primary Care & Community Services).

We then commissioned Newchurch, a consultancy firm with expertise in this area, to compare our services with services in London and across the UK. We also made comparisons between our services.

A summary of this work is at Appendix B. The main findings are:

- Compared to the range of costs provided by Newchurch for different PCTs, our cost per patient contact is generally in the middle, but is high for some specialist services
- Our number of contacts per staff member (whole time equivalent) are also generally in the middle of the range, high for some services, but low for some specialist services
- Staffing levels and cost per head of population are generally high compared with those outside London
- We generally have more skill mix than most PCTs (ie a wider range of grades of staff are used in delivering services)
- There are major opportunities to shift care from hospital to community – other PCTs are doing more.

### Market Analysis

We commissioned a study of future developments in the size and make-up of our population, policy directions, and the opportunities provided by new technology. Some key findings are:

- Our population and birth rate are both expected to increase and we must plan for this.
- We must plan for an increase in the number of people with long term conditions – this means more work to support self-care and more joined up working for people who are receiving care from a number of services.
- There are technological developments we could use to improve the quality and efficiency of community services, and allow more care to be delivered at home (e.g. remote working, telemedicine). However these won't work if they are introduced without underpinning knowledge management, care pathways and protocols. Put simply, it is what the patient or the clinician does with the information which really matters, and the way this links to the care someone else is providing.

We would be interested in your feedback on how we have taken these points into consideration in developing the vision in section 4, and whether they stimulate any other thoughts not included in that vision.

## User views and market research

Many of our services frequently seek feedback on the care they provide and use this to improve. However this is not done in a comprehensive way which allows us to make comparisons between services. In September we will send out a standard user questionnaire (which has been used by other PCTs in London) for each of our community services. Once all data is collected we can compare our results with other PCTs in London.

We have based several of the proposals in this paper on what service users have told us in previous consultations (such as the recent Long Term Conditions review). It is very important that we confirm whether the changes we are proposing make sense to service users. We will therefore carry out a market research exercise in September/October to test out some of the ideas in this paper with service users.

#### 4. Emerging vision and proposals

**“Over a quarter of a million nurses, midwives, health visitors, allied health professionals, pharmacists and others work in community health services. They have a crucial role to play in providing some of the most personalised care, particularly for children and families, for older people and those with complex care needs, and in promoting health and reducing health inequalities.”**

*Extract from High Quality Care for All, Lord Darzi's NHS Next Stage Review Final Report, July 2008, Chapter 5*

From all the above sources of information we have developed an emerging vision which we propose should underpin the future development of community services in Lambeth. The key points are as follows.

- We should develop services along **care pathways** to respond to both patient need and commissioners' requirements. This means that where someone has a long term condition or any condition that requires care from more than one professional (e.g. GP, community nurse and occupational therapist) teams should work in a way which joins up the different elements smoothly, governed by a predetermined process or “map” of care which is based on evidence and best practice. We have already made a start on this in some service areas e.g. stroke, autism assessment but there is more to do including looking at the Map of Medicine care pathways.
- We should **integrate** services where necessary, i.e. put them within the same organisational structure, to support working along care pathways. This may mean both a reorganisation of our current teams and a **different way of working in partnership**– e.g. through sub-contracting. This is explored further in section (b) below.
- We need to **improve the value for money** that we are providing. This is about quality as well as efficiency. For most services this means focusing on particular areas that have been shown to be expensive, and working out what we actually deliver for this – if the patient need is particularly complex then this could still represent good value for money. This work needs to produce changes that result in better care and a better experience for patients.
- At the same time we should **reshape and grow community services in order to help keep people at home** where possible rather than being in hospital – this is already our aim but we should be able to do more of it with a redesigned, integrated and expanded service. This is explored more at section (a) below.
- We need to **invest in and develop the skills of our workforce** in a more radical way particularly to provide the higher level of clinical skills needed to help keep people at home where possible rather than going into hospital. We also need to continue the development of customer service skills among our staff, and business skills among our service managers and team

leaders. We will be developing a workforce strategy during autumn 2008 which will take account of these needs, and also have an action plan in place following a recent review of clinical risk in our health visiting and community nursing teams.

- We need to **use technology better** to support working along care pathways – ie to link the services together using good technology but also supported by protocols on how clinicians will use the information they have to improve quality of care and patients' experience of their care. We need to examine whether our current Connecting for Health plans and timetables will deliver everything we need.
- We need to **increase access to community services** at times when patients want them, and to support GPs extending their hours – there are already several services provided during evenings and weekends (community nursing, sexual health) but there is also likely to be demand for other services at these times. We also need to make sure we are reducing inequalities in healthcare provision for people who might find it difficult to access traditional forms of care (e.g. homeless people, people who are moving around a great deal, people who work shifts).

This represents the high level vision and we would welcome comments. We are also making some more specific proposals on what the service models/structures might look like in broad terms, and what services the community services organisation might deliver in future.

#### **(a) How services are delivered – the service model**

Working along care pathways will mean reorganising our services into structures which support joined up working for people with particular needs. This does not necessarily mean a separate team for every condition (e.g. diabetes, stroke, end of life care) because many people will have more than one condition, and because we want to care for the whole person and not just their condition.

However it is likely to mean doing things differently from the way we do them now. Some services (e.g. rehabilitation provided by therapists) are already moving to a care pathway approach where the different professionals (physiotherapists, occupational therapists and speech & language therapists) work in a single team rather than as separate groups of professionals. But most of our other services – e.g. community nursing, health visiting, school nursing, podiatry, dietetics etc – operate as a group of professionals with a separate remit from another group, and often do not join up well when someone needs more than one form of care.

The Professional Reference Group looked at these questions from the following viewpoint:

- What do our services provide now?
- What would an ideal service working along care pathways look like?
- What are the differences?

From this work we are proposing a new model of care which is shown in outline form at Appendix C, and was approved by the Professional Reference Group. This is in very broad terms at the moment and clearly a lot more work is needed to determine what it means in detail, but in the descriptions below we have tried to pull out some examples of the differences it might make.

Firstly, for all services the functions of assessment, care planning and care delivery will be clearly separated. This does not necessarily mean that different teams will carry out these functions – they might be best kept in a single team and this needs to be looked at for each service to decide the best approach for their patients. What this should achieve is a clear understanding for both the patient and the care provider that a particular care pathway is being followed which is based on evidence, that choices can be made if appropriate at particular stages, and that it is clear why other professionals are being involved and what those people are there to do. It will therefore only work if the patient (or carer in the case of children) is actually involved in the process.

In relation to specialist services, the Professional Reference Group strongly felt that where appropriate these should be located with wider children's or adult/older people's services to enable joined up care –particularly for foot health services for older people, and dietetics services for older people and for children. Other specialist services, particularly for hard to reach groups, should probably remain separate in order to be able to target their client groups.

The group also felt there were strong reasons for joining up mental health services more closely with community services, since the people seen by community teams often have mental as well as physical health needs. This might be achieved by having mental health professionals in community teams (this has already been successfully done in the Refugee Health Team and commissioners have asked for it to be extended across the services for hard to reach groups).

### ***Children's services (see Appendix C section 2)***

The proposed model outlined in the Appendix would operate as a single children's services department within the community services organisation containing all children's community health services. The vision is for a service that joins up smoothly to support children and families with complex needs, building on the Team Around the Child model which is already used but strengthening that by bringing teams together.

This means that our current health visiting and school nursing services would be managed within the same structure as specialist children's services, rather than separately in localities as at present. This should make it easier to co-ordinate services for children with particular needs such as disabilities or special educational needs, addressing a major health need for the Lambeth population which has a high proportion of children with complex health needs. For example, a child with a disability can be receiving care from a health visitor, specialist nurse, physiotherapist, occupational therapist, speech and language therapist and specialist doctor as well as from social services.

It will of course be important for health visitors to keep their strong connections with GP practices and school nurses to keep their links with schools so they will continue to work in neighbourhood teams based out in the localities and linked to particular practices or schools, but be very much part of the overall children's services team.

Based on the work of the Professional Reference Group we propose a greater role than at present for health promotion and support services to families in Lambeth who face difficulties including single parents, young families, those on low incomes, from diverse backgrounds and those with mental health problems. We also see the potential to deliver more services outside hospital by extending the role of children's home care.

We propose some joint management of services with children's mental health services and children's social services provided by South London and Maudsley NHS Foundation Trust and Lambeth Council. This would fit with the outcome of the service analysis where specialist children's services were considered as possible candidates for integration with council services. If we start with joint management, full integration in a single organisation might be a longer-term objective – this links to the discussion on organisational forms below.

### ***Adult community services (see Appendix C section 3)***

Our vision is for a single integrated service for older people and people with long term conditions, covering community nursing (including end of life care), rehabilitation therapies and nursing, intermediate care (in beds and at home), podiatry and dietetics. We consider that this would fit with the draft Intermediate Care Strategy recently issued by commissioners, and with our aim of working along care pathways. The service would operate as a single department within the provider organisation.

It is important to keep neighbourhood teams working from locality bases and strengthen links to GP practices for the less specialist services, such as community nursing, but these will work as part of the overall structure. As proposed by the Professional Reference Group, there would be a greater role for health promotion for the elderly, and on lead professionals to "join up" services particularly for the frail elderly and help them navigate through health care systems.

We envisage that a natural evolution would be towards a "hospital at home" 24 hour service to support people to stay at home, to enable early discharge from hospital, or to support end of life care. This might mean for example that a patient with severe cellulitis or pneumonia who might currently be admitted to hospital for intravenous antibiotics and close supervision could receive this treatment at home with similar levels of care. This would clearly need different systems and higher levels of clinical skills and supervision than the services we currently operate, possibly working closely with partners such as the local GP co-operative SELDOC, which provides GP out of hours services. We would need a change in our culture to be able to run such a service and think this could be a very exciting direction for the future.

It would be crucial for such a service to work closely with social services and mental health teams. We could also consider some joint management with these teams. A move towards integration did not come out of the analysis as strongly as for children's services, but joined up working between these services is always a priority for patients.

### ***Primary and planned care (see Appendix C section 4)***

This group of services would contain:

- walk-in services (such as sexual health, clinics for the homeless)
- outreach services (such as health promotion, smoking cessation) and
- planned specialist care delivered in clinic settings (e.g. musculoskeletal physiotherapy, specialist sexual health), day case theatres (e.g. podiatric surgery) or in the home (e.g. HIV nursing, sickle cell case management).

Any expansion of our services around diagnostics or walk-in centres would fit well in this grouping.

Some specialist services within this group are already provided to other boroughs (mainly Southwark and Lewisham). Where services can demonstrate high quality and good value for money they could be candidates for marketing more widely.

## **(b) What services could be provided**

### ***Existing services***

We have started to look at all our services using the service analysis and other important sources of information (for example commissioning priorities set out in the PCT's 5 Year Commissioning Strategy). This is preliminary work and further analysis will be required as we further develop care pathways. A team of clinicians and managers have undertaken an initial scoring of the services according to a set of criteria which are at Appendix D. This also shows the weights we gave to each of the criteria.

The purpose of this piece of work was to use the information we gained about each of the services, and commissioning priorities, to develop proposals based on:

- our drive to improve the quality and cost-effectiveness of each service, so that we can develop excellence across all the services we deliver
- meeting the needs of the Lambeth population
- how best to organise services, including their fit with each other and delivering seamless services to patients.

The highest weight was given to whether the service fitted with our core business as a provider of community services, and the great majority of our current

services fitted with this. As a definition of our core business we used the following:

**The core business of Lambeth PCT Community Services is to provide:**

- **Services mainly to people who live, work or go to school in Lambeth**
- **Services mainly in out of hospital settings**
- **Skills or services that improve health outcomes**

We would like to know what you think about this. If from the feedback we receive we need to review our definition of our core business we can revisit the scoring we have completed.

Based on this initial scoring we divided our services into six groups according to potential future options. Some services appear in two or three groups as there needed to be more consideration. The categories and services in each one are in Table 2 below. We believe all community services currently provided by Lambeth PCT should continue into the future.

The analysis also includes some services which are not directly provided to the public but which support front line services – these include child protection support, health promotion support, service improvement support and data analysis services. These are services currently provided in the Primary Care & Community Services Directorate, but there are also support services in other directorates (such as infection control, facilities management, IT etc) which have not been included in this analysis so far and will need to be considered in the light of possible separation.

This work is at an early stage and we would like as many contributions as possible on whether these groupings are right. Clearly discussion with partner organisations where we are proposing consideration of integration or transfer to another organisation will be crucial.

**Table 2: Outcome of service analysis**

*\*denotes services which appear in more than one box*

Note that this analysis is on a service by service basis and does not take account of the overall potential benefits or disadvantages of organisational forms such as integration with another provider – these are covered in section (c). The proposed classification came out of the analysis described above.

Note also that the development of all services needs to take account of demographic change, e.g. expansion due to increasing birth rate.

<p><b>Group A</b></p> <p>Community services organisation provides. Look for opportunities to take on new business.</p>	<p>Adult therapies for complex and neurological conditions (physiotherapy, occupational therapy and speech &amp; language therapy)  Reproductive &amp; sexual health  Podiatry  Sickle cell service  *Musculoskeletal physiotherapy  *TB service  *Nutrition &amp; dietetics  Heart failure  Stop smoking services  Data analysis support to services  Specialist continence service</p>
<p><b>Group B</b></p> <p>Community services organisation provides. Services need some reshaping and can then be developed.</p>	<p>Community nursing (district nursing)  Community matrons  Supported discharge/rapid response  TACT  *Intermediate care wards  Health visiting  *School nursing  Homeless service  Drugs &amp; alcohol service  Refugee and asylum seeker services  HIV service  *TB service  Podiatric surgery  Acupuncture  *Children’s physiotherapy, occupational therapy and speech &amp; language therapy (as a first stage)  *Child health medical services (as a first stage)  *Children’s disability nursing (as a first stage)  Service improvement support  Health promotion support  Self-care support (expert patient programme)</p>
<p><b>Group C</b></p> <p>Community services organisation provides. Would benefit from economies of scale from merging with another PCT.</p>	<p>*Musculoskeletal physiotherapy  Child protection support (and reshape)</p>

<p><b>Group D</b></p> <p>Community services organisation provides. Consider integration or co-location with other services provided by partners.</p>	<ul style="list-style-type: none"> <li>*Musculoskeletal physiotherapy (with acute?)</li> <li>*School nursing (with local authority?)</li> <li>* Children’s physiotherapy, occupational therapy and speech &amp; language therapy (as 2<sup>nd</sup> stage, with local authority?)</li> <li>* Child health medical services (as 2<sup>nd</sup> stage, with local authority?)</li> <li>*Children’s disability nursing (as 2<sup>nd</sup> stage, with local authority?)</li> </ul>
<p><b>Group E</b></p> <p>Consider becoming independent service</p>	<ul style="list-style-type: none"> <li>*Continuing care beds (Minnie Kidd)</li> </ul>
<p><b>Group F</b></p> <p>Consider transfer to another provider that works closely with community services</p>	<ul style="list-style-type: none"> <li>*School nursing (to local authority?)</li> <li>* Children’s physiotherapy, occupational therapy and speech &amp; language therapy (as 2<sup>nd</sup> stage, to local authority?)</li> <li>*Child health medical services (as 2<sup>nd</sup> stage, to local authority?)</li> <li>*Children’s disability nursing (as 2<sup>nd</sup> stage, to local authority?)</li> <li>Services for looked after children (to local authority)</li> <li>*Intermediate care wards (to acute or independent sector?)</li> <li>*Continuing care beds (Minnie Kidd) (to acute or independent sector?)</li> <li>*Nutrition &amp; dietetics (to acute or another PCT?)</li> </ul>

Following discussion and formal consultation, the final range of services for the future community services organisation in Lambeth would be those services decided as being in Groups A, B, C and D. Please let us have your comments on the criteria, the groupings and these initial proposals.

***New services***

We have also considered which new services might fit with our vision and the proposed future range of services. The organisation would aim to take on these services by responding to tenders as these become available, or might do so through joining up with another organisation which already provides the services.

We have considered the following services and ranked them as high, medium and low in terms of their fit with the criteria we used for current services.

There are other services that we have not yet had time to consider, for example pulmonary rehabilitation, occupational therapy for the frail elderly, and we would welcome further suggestions to add to the list.

**Table 3: Possible new services**

High	<ul style="list-style-type: none"> <li>Ultrasound</li> <li>X-ray</li> <li>Blood tests</li> <li>Hospital at home</li> <li>Home oxygen therapy</li> <li>Children's home care</li> <li>Pre-operative and post-operative support</li> <li>Specialist tissue viability</li> <li>Adult protection support team</li> <li>Health trainers/health coaches</li> <li>Walk in centres</li> <li>Sigmoidoscopy (taking account of national screening programme)</li> </ul>
Medium	<ul style="list-style-type: none"> <li>Audiology for adults</li> <li>Telecare screening service</li> <li>Services in the community for adults with learning disabilities</li> <li>Home equipment provision</li> </ul>
Low	<ul style="list-style-type: none"> <li>Community dental services</li> <li>Breast screening (taking account of national screening programme)</li> <li>Patient transport</li> </ul>

We have also started to consider the issue of whether the community services organisation should take on providing private healthcare outside of NHS contracts, which is not currently done by community services within the PCT. This might be private provision on top of our existing services (eg podiatry, physiotherapy) or new service areas which are only funded privately (eg osteopathy). There are significant issues to be considered here around equity of service provision on the one hand, and sustainability and potential for income generation of the organisation on the other. Views on this are welcome.

### ***Primary care commissioning & contracting***

In addition to providing community services, the Primary Care and Community Services Directorate of the PCT is responsible for the commissioning and contracting of primary care independent contractors (GPs, dentists, pharmacists and optometrists).

A decision is needed on whether the future community service organisation should continue to include this function, sub-contracted from the commissioning arm of the PCT, or whether this should move to the commissioning arm of the PCT. A potential advantage of keeping it in the provider arm is the increased possibility of joint working between primary care and community services, which has been positive in recent years compared with previous experience of a more distant community services organisation. Another advantage has been a shared, cross cutting capacity for service improvement and the practical development of

integrated care pathways. However there could be disadvantages in separating primary care commissioning from the rest of commissioning where work is increasingly along care pathways.

The balance of advantage and disadvantage will depend on a variety of factors, including:

- any decision to integrate the provision of primary care and community services (possibilities for this such as an Integrated Care Organisation are included in section (c) below) and how best to commission this
- even without integration, the extent to which GPs and other primary care professionals are able to be involved and included in the organisation and strategic direction of community services – for example GP involvement in governance
- ultimately, the impact on patients and their health outcomes.

There is currently ongoing discussion on which is the better option for the future, and your views are very welcome on this point. The final decision is not wholly for the Fit for the Future process but is linked to other discussions taking place on the strengthening commissioning in the PCT.

During the discussion period we will be organising a workshop session for those involved in primary care commissioning to discuss these issues.

### ***Prescribing advice and medicines management***

The prescribing advice and medicines management function of the PCT is also currently within the Primary Care and Community Services Directorate. This service ensures quality and value for money in GP prescribing and supports the provision of community services through advice on prescribing and support to shifting care closer to home (e.g. through the development of non-medical prescribing). It also supports commissioning of primary care and of acute services. A discussion will therefore be needed on whether the future community service provider organisation should continue to include this function, which will be related to the wider discussion on the future of commissioning.

### (c) Organisational forms

Once we have determined our future range of services and service model, we need to decide on the best organisational form for delivering these services. In line with the government policies referred to at the beginning of this paper, remaining as we are or doing nothing is not an option. It has already been decided that in order to provide a sharper management focus and treat fairly all potential providers of community services, sections of PCTs currently responsible for service delivery must have a degree of separation from the commissioning part of the PCT.

PCTs across London have been debating these issues together with how to strengthen their commissioning functions, and have decided that all provider sections of London PCTs should be Autonomous Provider Organisations (APOs) by the end of March 2009. This means we must have a separate governing structure with a minimum of overlap with the PCT's commissioning responsibilities. Where there is an overlap there must be arrangements to ensure no conflict of interest. There must also be separate financial reporting arrangements, governance and accountability arrangements (audit, risk management etc), and service level agreements between the APO and corporate services such as HR and Finance.

Discussions across London also indicate that PCTs should consider a further step to a separate organisation, so that we can fulfil the vision for community services set out in the Next Stage Review and improve the quality of our Lambeth services for the benefit of everyone who uses them. This could be as a stand-alone organisation on our own or with one or more other PCT provider organisations, or by joining with another local partner. The table below sets out the options.

**Table 4: Possible forms for a separate organisation**

Linkages & Integration	Possible organisational form
A Stand alone organisation – on our own or partnership/merger with other PCT(s)	<ol style="list-style-type: none"> <li>1. Autonomous Provider Organisation within the PCT</li> <li>2. Community NHS Foundation Trust</li> <li>3. Social Enterprise / Community Interest Company</li> <li>4. Private Company</li> </ol>
B Integration with GP Practices, alone or as a consortium of practices	<ol style="list-style-type: none"> <li>1. Integrated Care Organisation</li> <li>2. Social Enterprise / Community Interest Company</li> <li>3. Private Company</li> </ol>
C Integration with Local Authority	<ol style="list-style-type: none"> <li>1. Children's Trust</li> <li>2. Care Trust</li> <li>3. Integrated provision through joint appointments with or without pooled budgets</li> <li>4. Integrated Care Organisation</li> <li>5. Arms Length Management Organisation</li> </ol>
D Integration/linkage with Acute or Mental Health Trust	<ol style="list-style-type: none"> <li>1. NHS Foundation Trust</li> <li>2. Organisation under the “umbrella” of Academic Health Sciences Centre – could be Community NHS Foundation Trust, Social Enterprise/CIC or Private Company</li> </ol>

In Appendix E we have set out some of the potential benefits and disadvantages of these options, based on some work done by the University of Birmingham.

We would like your views on the various possibilities. We are also developing criteria for assessing the various options, set out at Appendix F. If you let us know what rating you would give to the various factors, this will allow us to give a weight to each one which is based on the combined views of everyone who responds to us. Please fill in a questionnaire – there is one questionnaire for staff and another for partner organisations and service users.

There will be implications of these decisions for all staff in the PCT's Primary Care & Community Services Directorate, but also for staff in supporting directorates such as Finance and Information (including Facilities Management Services), Quality & Professional Development, and HR & Corporate Affairs, as well as for some in Public Health. This is because significant parts of their work are in support of provider services and there will need to be consideration of Service Level Agreements or possible transfer of some staff where the main part of their work supports the provider services or, if appropriate, the independent contractors. We therefore encourage staff across the whole PCT to contribute to the discussion and fill in questionnaires.

Options which involve linkage or integration with partner organisations will obviously require close consultation with those organisations on their own future plans.

## 5. Next Steps

Our proposed timetable for discussion, consultation, making decisions and implementation is as follows.

Aug 2008	Publish informal discussion document on range of services, service model and future organisational form.
During Sept 2008 – Mar 2009	Preparation work will be taking place to become an Autonomous Provider Organisation (APO) as discussed in section 4(c).
Sept-Oct 2008	Discussions with all PCT staff and partner organisations (GPs, Lambeth Council children's and adult & older people's services, Guys & St Thomas, Kings and SLAM Foundation Trusts and the voluntary sector). This will include a GP conference and a conference for voluntary organisations. A workshop will also be held for staff involved in primary care commissioning  Market research with service users.  We will also undertake an equality impact assessment screening of the proposals.
Nov 2008	Assess discussion responses and change proposals as appropriate. Develop a short list of organisational forms and undertake full analysis.  Make recommendation to PCT Board on move to APO and future organisational form (if work on this completed).
End Nov 2008	Board decision on preferred recommendation
Dec 2008 - Mar 2009	3 month formal consultation on Board decision
April 2009	Following consultation, final decision on service structures and future organisational form.
During 2009/10	Implementation of decision – timetable will depend on the option chosen. If a decision is taken to separate, we believe it is essential to have a substantial lead-in period to implementation in order to ensure this is done in a thorough and well-ordered way, taking full account of the implications for corporate and support services and ensuring we keep staff on board.

## **6. How will this affect me?**

This section sets out implications of the process and proposals in this paper for Lambeth PCT staff. For service users, a market research exercise will be carried out which will make clear what the proposals might mean for them. We will aim to ensure that changes are carried out without disruption to services.

### ***How will this affect my job?***

For the majority of staff in the Primary Care & Community Services Directorate or in other Directorates of the PCT, the initial move in April 2009 to become an Autonomous Provider Organisation will have very little impact on their jobs. This move is mainly about clearer separation of governance and financial arrangements. One impact is likely to be to clarify, for staff in supporting directorates such as Finance and Information (including Facilities Management Services), Quality & Professional Development, and HR & Corporate Affairs, the aspects of their work which support community services as compared to other parts of the PCT.

There will however be implications for staff in the Primary Care & Community Services Directorate from the new models of service delivery discussed in section 4 above, which could result in changes in the way we deliver our services – subject to the feedback we receive from this discussion process. Any major changes will be included in the formal consultation in late 2008/early 2009.

In the longer term there will be a change in the form of the organisation providing community services, in order to give greater freedom to those delivering the services and improve their quality for the benefit of the Lambeth population. There is no decision yet on what this change will be, and this discussion process is about finding out your views on what you think is important in deciding on the future direction. There will be a formal consultation on this including a full option appraisal of the preferred organisational forms.

### ***How will I be supported during this process?***

We have organised staff events and drop-in sessions for you to come along and give your views and ask questions – details are at Section 7 below. You can also invite us to your team meetings for a discussion. We will listen carefully and take account of your views and possible concerns, and respond to them.

As the implications of the new direction become clearer, we will do our utmost to support staff who are affected, and also enable you to participate in the discussions about your future organisation. We are aware that change creates anxieties and also new opportunities, and we are committed to being as open and transparent as possible about what is happening.

### ***What is happening in other PCTs?***

All PCTs, both in and outside London, are going through a process of deciding on the future of their community services provider arms. It is likely that a range of different types and sizes of organisation will result from this process, depending on local circumstances.

## 7. How to contribute to the discussion

We are publishing this document in order to have an informal discussion with staff, partners and service users about these proposals. We would like to hear what you think. To take part in the discussion you can:

- attend one of the lunchtime staff events on 2<sup>nd</sup>, 11<sup>th</sup> or 24<sup>th</sup> September
- come to one of the staff drop-in sessions on 6<sup>th</sup>, 13<sup>th</sup>, 16<sup>th</sup> or 17<sup>th</sup> October
- attend the GP conference on 23<sup>rd</sup> September
- attend the voluntary sector workshop on 3<sup>rd</sup> October
- fill in the feedback section at Appendix F at the back of the paper
- invite us to any event that you are organising.

Details of all these events are below. To notify your attendance please email [angela.odunsi@lambethpct.nhs.uk](mailto:angela.odunsi@lambethpct.nhs.uk) or phone Angela on 020 3049 4073.

We will also be arranging meetings with other partner organisations and a further meeting of the Professional Reference Group. We will be organising a workshop session for those involved in primary care commissioning.

Please feel free to let us have written comments even if you also attend one of the events. We would also like everyone to complete one of the questionnaires at Appendix F to let us know what you think is most important in the decision about our future organisational form. There is one questionnaire for staff and another for service users and partner organisations.

**All comments and questionnaires should be sent back by 17 October. Details of where to send your feedback are at Appendix F. We look forward to hearing your views.**

### Staff events

Dates, times and venues are as follows:

Date	Time	Venue
2 <sup>nd</sup> September	12.00-13.30	Sunny Hill House Sunny Hill Road Streatham SW16 2UG
11 <sup>th</sup> September	12.00-13.30	Old Library Centre 14 - 16 Knights Hill West Norwood London SE27 0H7
24 <sup>th</sup> September	12.00-13.30	YMCA King Georges House 40-46 Stockwell Road Stockwell London SW9 9ES

## Drop in sessions

Dates, times and venues are as follows:

Date	Time	Venue
6 <sup>th</sup> October	12.00-13.00	Gracefield Gardens Joint Service Centre 2-8 Gracefield Gardens Streatham SW16 2ST
13 <sup>th</sup> October	12.00-13.00	Railton Road Health Centre 143-149 Railton Road Herne Hill SE24 0LT
16 <sup>th</sup> October	13.30-14.30	Mary Sheridan Centre (Wooden Spoon House) 5 Dugard Way (off Renfrew Rd) Kennington SE11 4TH
17 <sup>th</sup> October	12.30-13.30	Lower Marsh 2 <sup>nd</sup> Floor Room 204

## GP conference

Date: 23 September 2008

Time: 1pm-4pm

Venue: Council Chamber (1<sup>st</sup> Floor)  
Royal Pharmaceutical Society  
1 Lambeth High St  
London SE1 7JN

## Voluntary sector workshop

Date: 3 October 2008

Time: 1pm-4pm

Venue: YMCA  
King Georges House  
40-46 Stockwell Road  
Stockwell  
London SW9 9ES

## APPENDIX A

### Summary of discussions, Professional Reference Group, Fit for the Future Programme, Lambeth PCT 2008

#### Members of Professional Reference Group

Karyn Greene – Customer Service Team Leader Lambeth PCT  
Cathy Ingram – Service Manager, Adult Therapies, Lambeth PCT  
Joni Graham – GP Practice Manager  
Parveen Akhtar – Senior Nurse Lambeth PCT  
Moira Dick – Lead Consultant Paediatrician, Lambeth PCT  
Martin Sharp – Carers' Advocate, Lambeth Carers  
Jill Solly – Head of Primary / Secondary Care Interface, Kings College Hospital NHS Foundation Trust (also representing Guys & St Thomas's NHS Foundation Trust)  
Rupert Maher – Deputy Service Manager, Foot Health, Lambeth PCT  
Jean Spencer, Manager of Psychosis Care Pathway Project, Lambeth PCT  
Julia Shelley - Chief Executive, Age Concern Lambeth  
Frances Dudley – General Practitioner North Locality, Lambeth  
Adrian McLachlan – General Practitioner, South West Locality, Lambeth  
Sandra Morrison – Divisional Director Change Management and TAC, Children and Young People's Service, London Borough of Lambeth  
George Marshman – Divisional Director Adult Social Care Adults and Community Services, London Borough of Lambeth  
Mike Reid – Clinical Coordinator, South London & Maudsley NHS Foundation Trust  
Susan Tirbutt – Patient's Forum  
Ginny Morley-Facilitator  
Heather Blake- Assistant Director, Long Term Conditions & North Locality  
Philipsia Greenway-Provider Development Programme Manager  
Angela Odunsi-Provider Development Programme Co-ordinator

#### Children's Services

The Professional Reference Group discussed the core elements they wished to see incorporated into future services for children and their perceptions of how current services differed from a model of service they wished to see develop. This was based on the series of presentations at the January 2008 meeting and their experience and understanding of services.

They recognised the proposed significant increase in the numbers of children living in Lambeth in 2012, in particular the numbers of children aged under 9. They noted the need for action in the prenatal/maternity and early years including promoting nutrition and breast feeding, as well as other areas for change including accident prevention and parenting support. The group further endorsed the need for action for adolescent and youth health including better integration of health and other youth oriented service providers as well as school health services and training of CYP staff in core areas such as alcohol, substance misuse etc

In discussing services for children the group indicated support for the continued development of a wide range of services for children and the potential in particular of working with partner agencies such as the local authority through initiatives such as the 'Team around the Child'. The large number of potential agencies identified by the group as currently involved in children's services in Lambeth emphasised the need for excellent communication and joint working between the relevant agencies.

The Professional Reference Group acknowledged the need for specialist child health services to be provided where needed to support an increasing population of children with disabilities living in the community. The group requested any information about benchmarking specialist child health services with other areas as it was felt this would be useful.

It was recognised that there is a continuing need for primary and acute services for children to work together and to enable further changes in the pattern of service provision. Through discussion the group identified that it would be possible for services for children currently provided in hospital to be provided in the community for example through the development of more hospital at home facilities for children as well as some conditions where children currently attend hospital outpatients who could be seen in the community. It was suggested that there was potential for joint working between the hospital trusts and the PCT to identify the nature and extent of the scope of work that could be managed at home.

Interest was expressed in scrutinising the care pathway for children through 'universal' services provided for all children in Lambeth to the more targeted and the specialist child health services. Any pathway would also involve primary care, the local authority and voluntary agencies.

Concern was expressed that the current divisions of service organisation in child health were not useful. It was noted that a lack of clarity in distinguishing between outpatient and specialist children's services meant there was potential for overlap and duplication as well as confusion.

There was a wish to offer greater family support services to families in Lambeth who faced difficulties including single parents, young families, those on low incomes, from diverse backgrounds and those with mental health problems. It was felt that more preventative interventions with the large range of families facing difficulties would have clear benefits for users in receiving more timely and appropriate health care as well as being more cost effective for the service through minimising inappropriate consultations and treatment.

The group also identified a large range of other agencies they see as essential partners in developing services for children in Lambeth. The group said they felt there was a need to confront a history of limited joint working with the local authority and change the relationship to improve opportunities for integrated approaches. They said that it would be useful to look at models of children's trusts operational elsewhere in order to identify the range of possibilities and benefits to the service of these models of working even if these particular models were not appropriate.

## **Adult & Older People's Services**

The Professional Reference Group discussed the core elements they wished to see incorporated into adult and older people's services for the future and their perceptions of how current services differed from their preferred model of service. They also considered the network of agencies that are involved locally in adult and older people's care. This was based on the series of presentations at the March 2008 meeting and their experience and understanding of services.

The group identified this as a large service area which required a large number of core elements to be incorporated into the future of adult and older people's services. These covered a considerable range from prevention through to identifying those at risk of hospital admission including the following:

- greater emphasis on prevention for the elderly including health promotion.
- the need for improvements in the quality of home care support available for the elderly both in terms of the services delivered to adults and older people and in the commissioning of these services.
- enhancing the role of advocacy for elderly patients. It was clear that change in the use of IT to enable booking and access was often more challenging for older people and that older people would benefit from an advocate at home to facilitate their effective use of health care.
- a lead/professional key worker to assist navigating an older peoples way through the system. It was acknowledged that where adults and older people were in receipt of services from a number of providers it could be helpful to have one lead professional take on a coordinating function to avoid repetitive interventions from numerous services.
- developing the relationship between district nurses and the community geriatricians and implementing a means of identifying high risk patients.
- The group noted that there was a need for a greater range of skill mix for nursing in the community due to the move to earlier discharge of patients with more complex needs being cared for at home.
- developing a different model of intermediate care appropriate to the needs to adults and older people in 2008 and beyond.

Overall there was the impression that the current pattern of provision was seen by the group to be insufficient to support increasing numbers of frail elderly people in the community. The vision of care involved a wider sense of carer support and advocacy on behalf of older people and a significant improvement in services developed in partnership with other agencies. It was important to use a common language wherever possible e.g. as with the common assessment framework

It was recognised that any shift in the provision of care from the acute sector whether it be SLAM or any other acute trust needed to be supported by the setting up of appropriate infrastructure to adequately support services and an understanding that to support a service change there would need to be a programme of cultural change.

It was stated strongly by the group that greater integration and real joint working with the local authority would make a big difference to the services that could be provided to patients. The group noted that initiatives in areas such as Croydon seemed to have made more significant progress in developing effective models of care than had been possible locally to date.

### **Specialist Services**

The Professional Reference Group discussed the core elements they wished to see develop in specialist services for the future and their perceptions of how current services differed from their preferred model of service. They also considered the network of agencies that are involved locally in specialist services recognising that key linkages with other agencies were critical in this area. This was based on the series of presentations at the February 2008 meeting and their experience and understanding of services.

This group of specialist services presented an interesting challenge for the Professional Reference Group as although they are clustered together for service management purposes it was acknowledged that this was largely historic rather than purposeful and that they don't all easily fit together currently. Two of the specialist services work across and outside the Lambeth borough boundary and these are the hard to reach team and the sickle cell team.

The overarching theme to emerge from the group's discussion about these services was the need for integration of these services wherever possible with mainstream services whilst not losing sight of the specialism and expertise. For example nutrition and dietetics was identified as an area where there would be considerable benefits from greater integration with adult and children's services. It was also clear that there were possibilities elsewhere for more integration of specialist with mainstream services for example podiatry where work links very closely with the provision of care for elderly people with diabetes.

Sickle cell services were a group where their expertise would appropriately work outside the immediate borough providing a service in areas where there is not such a concentrated need for the service or where services are not well developed. It was also suggested that as a service they may wish to review the balance of services they currently provide in hospital and in the community.

It was noted that those services that were not appropriate for integration stood out as having elements of dealing with issues associated with social exclusion and that there was a safeguarding role within the services. It was noted that all of these services had an element of education and health promotion as part of the service as well as direct client care.

The group suggested it may be appropriate to review the size and scope of some of the specialist services including 24 hour access in order to consider more carefully and in more detail the strategic fit of this range of services for example hard to reach services.

The group endorsed the direction of sexual health services and their move towards greater provision of services outside of a hospital setting.

## APPENDIX B

### Summary of Service Analysis and Benchmarking

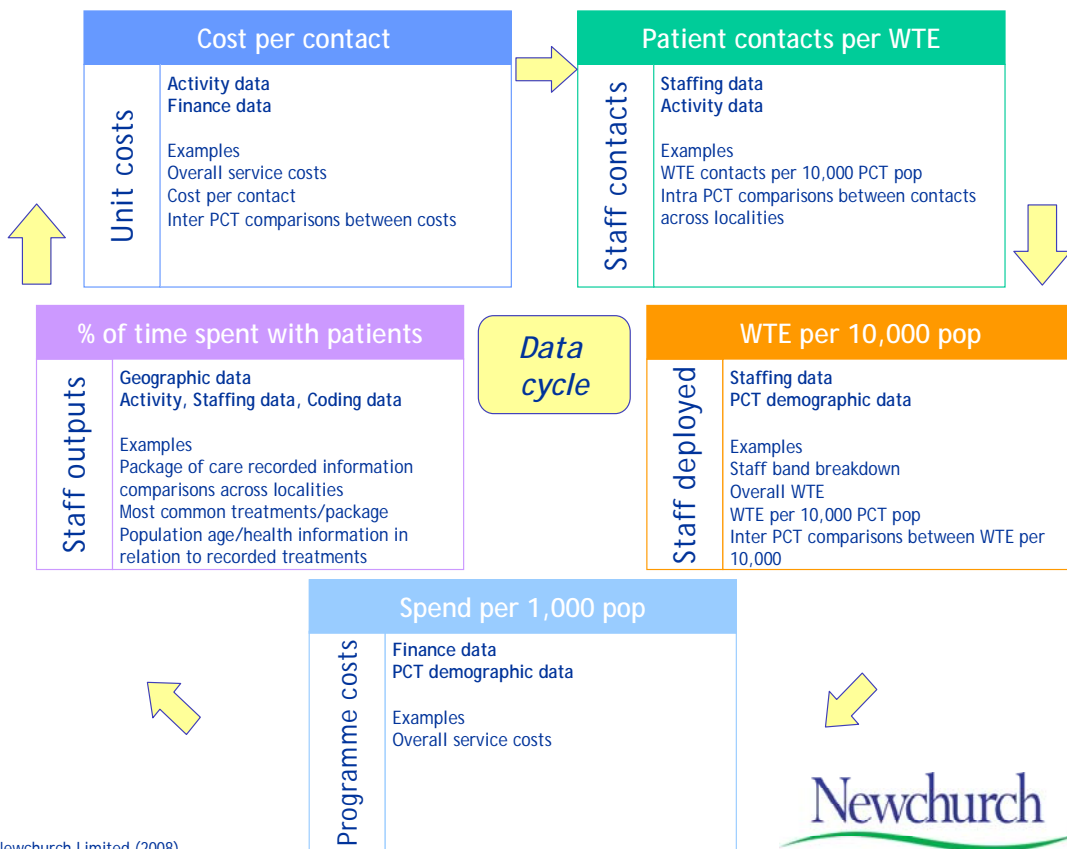
We received data from all our 36 directly managed services broken down by component parts of the services.

For each component, services were asked to analyse / provide data based on

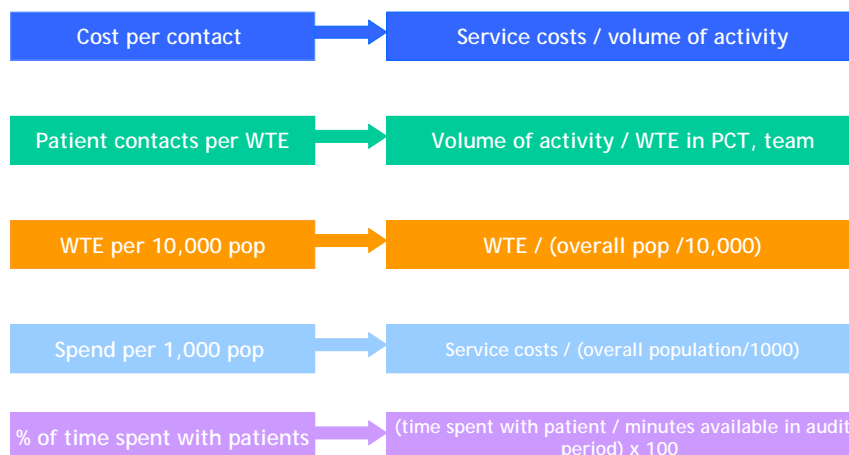
- Service cost by components
- Activity
- Service Visions
- Quality and Effectiveness.

Newchurch took the data for each service and benchmarked this against other PCT data in their database. The Key Metrics and data cycle below illustrates how the data was used to produce figures for benchmarking.

#### Key metrics and data cycle



## How key metrics are derived



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It was not possible to benchmark all of our services with other PCTs as their services did not always have enough similarity to ours to make the benchmarking valid. Benchmark PCTs included both London PCTs and PCTs from elsewhere in the country, but always from urban areas resembling ours as closely as possible. Services benchmarked were:

- District nursing
- Health visiting
- School nursing
- Podiatry
- Specialist child health – Physiotherapy and Speech & Language Therapy
- TB

For some of the services not benchmarked, Newchurch undertook a qualitative analysis of other leading edge services and compared our services to these. This was done for:

- Homeless and refugee services
- Sexual health
- Intermediate care

## **Broad findings from benchmarking**

1. Our cost per contact is generally in the middle of the range for most services, but looks high for some specialist services such as specialist child health. This may be due to the complex nature of the service and needs further investigation.
2. Our contacts per whole time equivalent are also generally in the middle of the range and look particularly efficient for some services (podiatry, musculoskeletal, physiotherapy). However they are again low for some specialist services.
3. Our staffing levels and cost per head of population are generally higher than those outside London, with the exception of district nursing.
4. We generally have a greater degree of skill mix than other PCTs.
5. For some services our staff are at generally higher grades than the benchmarked PCTs, for others they are lower.
6. There are major opportunities for further shift of care outside hospital – others are doing more.

## **Broad findings from analysis of leading edge services**

- Sexual Health - Lambeth compares well to other leading edge services but can learn from marketing initiatives used elsewhere.
- Homeless and Refugee services – several areas of improvement can be made.
- Intermediate Care – there is scope for us to be much more innovative.

## APPENDIX C: PROPOSED SERVICE MODEL

### 1. GENERAL MODEL TO APPLY TO ALL SERVICE AREAS

*Assessment service*



*Care planning service*



*Care delivery service*

For each service there will be a decision on whether to “make or buy” – whether to do it ourselves or contract to someone else.

The care delivery service would also contain elements of lower level assessment and it will be important not to lose these skills in health care professionals.

It will be important for the feedback loop between the different stages to work smoothly – this element could become bureaucratic rather than operating as part of the system as at present.

## 2: CHILDREN'S SERVICES

The proposed model would operate as a single children's services department within the community services organisation containing all children's community health services. There would be functional integration with CAMHS and children's social services in line with the Team Around the Child, with organisational integration as a longer term objective. Co-location is expected to bring significant benefits.

<p><b>Universal services North</b>          Health visiting          School nursing          Nutritionists          Children's speech &amp; language therapy          Children's clinics e.g. asthma</p>	<p><b>with links to</b>          GPs          Midwifery          Pharmacy</p>
<p><b>In Neighbourhood Resource Centres or Children's Centres</b></p>	

<p><b>Specialist service centre</b>  <b>in middle of Lambeth including</b>          Health services for children with disabilities          Health services for children with special educational needs          Safeguarding          Children's home care          Sickle cell specialist care for children          Sickle cell genetic counselling          Dietetics for children with special needs          Services for looked after &amp; vulnerable children          Children's mental health services including early onset          Social services for children &amp; families          Voluntary sector provision for children &amp; families  <b>offered by a range of providers</b></p>
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<p><b>Universal services SW</b>          As above</p>	
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<p><b>Universal services SE</b>          As above</p>
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### **3: ADULT COMMUNITY SERVICES**

**The model below would operate as a single organisational department within the community services organisation. There would be neighbourhood teams working from locality bases for the less specialist services with close links to GPs, as for children's services, but these would be part of the overall organisational structure.**

#### **Care delivery service**

##### **A fully integrated service which includes:**

- Case management
- Supported discharge
- Beds
- Rehabilitation – home and centre-based
- Personal care
- Leg ulcer care
- Wound care
- IV therapy
- Tissue viability
- Continence and catheter care
- Palliative care
- Dietetics
- Podiatry

##### **Working along pathways such as:**

- Diabetes
- COPD
- Stroke
- Heart failure
- Dementia
- Fall prevention
- End of life care
- Sickle
- etc

This list of care pathways is just a start and needs to be expanded – we will look at the Map of Medicine as an initial basis for this and would also welcome suggestions for appropriate care pathways.

For particularly vulnerable adults and older people the service would form a "Team around the Adult" as currently in place for children. This would require closer working with social services, mental health teams, voluntary sector groups and carers.

#### **4: PRIMARY AND PLANNED CARE**

Specialist podiatry eg biomechanics (suggest some rotation of staff between this service and the adult community service to maintain skills)

Podiatric surgery

Reproductive & sexual health

Musculoskeletal physiotherapy

Acupuncture

Services for hard to reach groups:

- Homeless
- Drugs & alcohol
- Refugees & new migrants
- HIV
- Sickle cell

Heart failure

Smoking cessation

Health promotion

Self-care/expert patient programme

## APPENDIX D

### Scoring framework for service lines

Service Name:

Yes scores high  
No scores low  
\*exception

<b>Criteria</b>	<b>Weighting</b>	<b>Score (1-5)</b>	<b>Score x Weighting</b>
Fits into Provider Service's core business	30		
Does the service appear to be good value for money?	10		
Does the service demonstrate that it meets quality standards?	10		
Does it build, or have the capability to build, good relationships with partners?	5		
Does it lend itself to working within a care pathway?	5		
Does it fit with commissioning priorities?	10		
Does it develop or have the potential to develop services outside hospital/ bring services closer to home?	5		
Is there a dependence on other service lines?	5		
Does it contribute to economies of scale?	5		
*Is another provider better placed to manage the service? (yes scores low, no scores high)	5		
Does the service have a reputation for innovation and flexibility?	10		
<b>Totals</b>	<b>100</b>		

**APPENDIX E: POTENTIAL BENEFITS AND DISADVANTAGES OF ORGANISATIONAL FORMS**  
(based on work by University of Birmingham)

<b>Linkages &amp; Integration</b>	<b>Organisational Form</b>	<b>Benefits</b>	<b>Disadvantages</b>
Stand alone organisation – on our own or partnership/merger with other PCT(s)	<ol style="list-style-type: none"> <li>1. Autonomous Provider Organisation within the PCT</li> <li>2. Community NHS Foundation Trust</li> <li>3. Social Enterprise / Community Interest Company</li> <li>4. Private Company</li> </ol>	<p>APO and Community Foundation Trust offer a functional rather than a structural solution and may be more easily realised.</p> <p>NHS terms &amp; conditions Community engagement Rigour of Monitor process to ensure viability</p> <p>Social Enterprise / CIC will be monitored by a regulator to ensure community interest is satisfied</p> <p>Well known established model, operated as a separate legal entity</p>	<p>No external drivers or challenge in relation to excellence</p> <p>High management overheads unless join up with another PCT</p> <p>Largely untested model No NHS pension body status but may achieve direction status for transfer of NHS staff pensions</p> <p>No NHS terms &amp; conditions</p>
Integration with GP Practices, alone or or as a consortium of practices	<ol style="list-style-type: none"> <li>1. Integrated Care Organisation</li> <li>2. Social Enterprise / Community Interest Company</li> <li>3. Private Company</li> </ol>	<p>Facilitates Care Pathway solution ?NHS terms &amp; conditions</p> <p>Financial incentives towards systems efficiencies</p>	<p>Potential for monopoly provider Untested in the UK</p> <p>Accountability framework to be developed with commissioning PCT</p>
Integration with Local Authority	<ol style="list-style-type: none"> <li>1. Children's Trust</li> <li>2. Care Trust</li> <li>3. Integrated provision through joint appointments with or without pooled budgets</li> </ol>	<p>Integration across organisational boundaries can preserve existing staff benefits.</p> <p>Established and flexible model suitable for a large number of situations</p>	<p>Frictions from 2 system approach (health &amp; social care)</p> <p>Potential ambiguities over extent of responsibilities</p>

	<p>4. Integrated Care Organisation</p> <p>5. Arms Length Management Organisation</p>	Facilitates Care Pathway solution	Constitutionally complex in practice
Integration/linkage with Acute or Mental Health Trust	<p>1. NHS Foundation Trust</p> <p>2. Organisation under the “umbrella” of Academic Health Sciences Centre – could be Community NHS Foundation Trust, Social Enterprise/CIC or Private Company</p>	<p>Facilitates Care Pathway solution</p> <p>Financial incentives towards systems efficiencies</p> <p>NHS terms &amp; conditions</p>	<p>Potential for monopoly provider</p> <p>Untested in the UK</p> <p>Structural difficulties can be avoided by virtual integration</p>



## QUESTIONNAIRE FOR STAFF

Please let us know what you think is most important in the decision about our future organisational form, by filling in the questionnaire below

Name:

Role:

Please give a rating of **1 to 5** to each of the following factors, where **1 is low and 5 is high**

Factor	Rating
Provides a wide range of services	
Provides opportunities for joined up care	
Provides services recognised as excellent	
Maintains terms and conditions of employment eg pensions	
Is able to recruit and retain high quality staff	
Is able and flexible enough to support new ways of working (eg through reinvestment of surpluses to improve services)	
Provides opportunity for staff to be involved in organisation's governance and decision making	
Strengthens clinical leadership	
Provides potential for career development	
Has links with bodies of research and academia to assist professional development	
Is robust and stable for the future	
Keeps NHS status	
Helps partnership working	

Please send the feedback form and questionnaire to:

Angela Odunsi  
Lambeth PCT 1st Floor  
1 Lower Marsh  
Waterloo  
London SE1 7NT

If you would like to fill the form and questionnaire in electronically please use the link on the PCT intranet or email Angela on [angela.odunsi@lambethpct.nhs.uk](mailto:angela.odunsi@lambethpct.nhs.uk)

## QUESTIONNAIRE FOR PARTNER ORGANISATIONS AND SERVICE USERS

Please let us know what you think is most important in the decision about our future organisational form, by filling in the questionnaire below

Name:

Organisation (if applicable):

Please give a rating of **1 to 5** to each of the following factors, where **1 is low and 5 is high**

Factor	Priority
Provides a wide range of services	
Allows for a choice of services and convenient times to access services	
Provides a framework to increase quality of healthcare and improve the health of the population	
Flexible enough to innovate and change to meet user needs	
Grounded in Lambeth	
Provides opportunities for joined up care	
Strong community and service user involvement	
Meets the needs of vulnerable groups	
NHS brand	
Clinically driven	
Strong connections with GPs	
Strong connections with local authority services	
Strong connections with hospital and mental health services	

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