Ealing and Harrow Community Services

Ealing Hospital
NHS Trust

NHS
Harrow

NHS
Ealing

# Integrated Care Organisation

## Business Case

# Part 2 Attachments 1- 8

***"Committed to Local Healthcare"***

## ATTACHMENT 1

## EHT Process to Becoming an ICO

EHT originally intended to become a Foundation Trust in its own right. An application was submitted which received SHA approval in October 2007. Deloitte then completed the historic due diligence phase and the Monitor assessment phase began. At the Board-to-Board in February 2008, the Trust was told that its application could not be approved as a result of the uncertainty surrounding the impact of Healthcare for London.

The Trust undertook further work during the summer of 2008, but it was by then becoming clear that the provider landscape would need to change dramatically across London if *Healthcare for London* was to be implemented in an affordable manner. In November 2008 the SHA expressed the view that EHT could not achieve Foundation Trust status in its current form.

In January 2009 the EHT Board made the decision to withdraw the Trust's FT application on 28th February 2009. At that time the Board considered 3 possible ways forward: merger with an existing NHST, acquisition by a Foundation Trust or vertical integration with Ealing PCT's provider arm.

EHT was fully engaged in the provider landscape work being undertaken across the North West London sector. From 1 April 2009, Ealing PCT's provider arm joined with Harrow's provider arm (APO).

At its March 2009 meeting EHT's Board considered a strategic paper looking at the 3 possible ways forward as described above. It was agreed that the Trust would explore vertical integration further as its preferred option.

In June 2009 the Board discussed the potential for integration with both Ealing and Harrow community services in the light of the development of the joint APO. The Board also discussed the difficulties across north west London as a sector and concluded that merger or acquisition by/with another acute provider would be very difficult given the issues faced by neighbouring hospitals (and in some cases the detrimental effect merger discussions would have on other Trusts' FT applications).

On 15 July the Boards of NHS Ealing, NHS Harrow and EHT held a joint workshop to explore the possibility of joining together to create an Integrated Care Organisation (ICO). This was followed by agreement at EHT's July Board that this was the preferred option.

A Strategic Outline Case (SOC) was considered and approved by the September Board with a view to approving a business case in November 2009.

**ATTACHMENT 2**

# Options Appraisal on the Future Organisation for Ealing and Harrow Community Services

## 1. Executive Summary

This paper presents an appraisal of the various options for the future organisation of community health services in Ealing and Harrow.

It aims to establish a medium and longer term organisational future for these services, which would achieve full separation from the commissioning PCTs (NHS Ealing and NHS Harrow) and launch the community services in an organisation in which they can thrive and develop further.

A number of **environmental factors** are described in the paper. The transformation of community services is a highly important initiative for the NHS as a whole, and an organisational option which would support this transformation would be a distinct advantage. The market for community services is developing and likely to accelerate, requiring services to be able to compete on quality and price, and be supported by an organisation of sufficient size and breadth. Continuing to have a strong borough focus is important for community services. Integration with local authority services remains a significant factor, and there is potential for further integration in the future. The financial outlook means that there is a particular need to consider options which would enable savings to be made.

A range of possible **organisational forms** are considered, in the knowledge that the only forms deemed acceptable in the long run will be Community Foundation Trusts, Foundation Trusts, or Social Enterprises. A number of other options have been ruled out.

Nine **criteria** are used to assess the options, each of which is considered in some detail:

Criterion 1: Full Separation from Commissioners
Criterion 2: Capability to Transform Community Services
Criterion 3: Focus on Transforming Community Services
Criterion 4: Able to improve services beyond Ealing and Harrow
Criterion 5: Attracts Staff to Work in Community Services
Criterion 6: Viability: Balanced Budget; Capital; and Revenue
Criterion 7: Viability: Likely to Grow, and Withstand Losses in Services
Criterion 8: Scope to reduce spending on overheads and inefficiencies
Criterion 9: Meeting Commissioners’ Aspirations

Six **options** are then described, each of which involves an interim phase before progressing to a long-term form:

Option A A Directly Provided Organisation within Ealing PCT, becoming a Community Foundation Trust

Option B A Directly Provided Organisation within Ealing PCT, becoming a Social Enterprise

Option C A Directly Provided Organisation within another Trust, becoming a Community Foundation Trust

Option D Join a Major Acute Trust becoming part of a Foundation Trust

Option E Create an Integrated Care Organisation becoming a Community Foundation Trust

Option F Join Another Community Services Provider becoming a Community Foundation Trust

A **scoring event** was held involving 49 people: staff side representatives, clinical and managerial leaders, and members of teams, from across the organisation's services. This group individually scored each of the options by criteria 2-5 and their results were collected. Criteria 1 and 6-9 were scored by the directors of Ealing and Harrow Community Services.

The **results** are shown below:

**EHCS Options Appraisal Results**

This shows a clear result in favour of Option E, the Integrated Care Organisation.

The next highest option is option D, joining a Major Acute Trust, closely followed by option E, joining Another Community Provider.

All three options involving remaining a Directly Provided Organisation score very similarly.

As is normal in an options appraisal, a detailed **sensitivity analysis** was undertaken, to see if there were factors which if changed would materially affect the result. Its conclusion is that whichever way the scores or weights or criteria were altered in the sensitivity analysis (even to some rather unreasonable extremes), option E continued to be the option scoring the highest. This is because option E scored highest on six out of the 9 criteria.

For example, both groups, the staff and the directors scored a similar pattern for the criteria they were scoring. Also, if the criteria were to be weighted differently, then criteria 5, 6 and 7 would all have to be weighted as 6 times more important than all the other criteria before Option E ceased to be the top scoring option.

There is therefore a clear **conclusion** that option E, the creation of an Integrated Care Organisation is the preferred option from this Options Appraisal, and that this should be recommended to the Provider Alliance Board.

The **recommendation** is therefore that :

> The Provider Alliance Board agrees to recommend to the Boards of NHS Harrow and NHS Ealing the creation of an Integrated Care Organisation, preferably from April 2010, by the transfer of services and staff into Ealing Hospital NHS Trust, on the basis that there will be a new name and changes to its legal purposes to reflect its new role.

The **next steps** are that the recommendation will be considered by the Boards of NHS Harrow and NHS Ealing, who are the decision making bodies.

A more detailed business case for creating an Integrated Care Organisation will be prepared, for consideration by the two PCT Boards, and the Ealing Hospital NHS Trust Board, at their respective meetings in October or November.

If the decision is taken to create the Integrated Care Organisation, then a detailed implementation plan will be created with the aim of making the change on 1 April 2010. This would include formal consultation with staff on the transfer of employment from the two PCTs.

It is not envisaged that this change would require a formal public consultation, as it is a change in the organisations, rather than a major change in services to patients.

A process of due diligence would also take place to ensure all parties are assured of the status and risks involved in making the transfer.

## 2. Purpose

This paper presents an appraisal of the various options for the future organisation of community health services in Ealing and Harrow. It considers a range of options, from moving to become a new independent body with its current group of services, by a range of different routes, through to joining with a range of other organisations.

It is to be considered by the Provider Alliance Board of Ealing and Harrow Community Services, at its meeting on 16 September 2009. That meeting will make a recommendation to the Boards of NHS Ealing and NHS Harrow, who are the decision making bodies for this type of decision. The decision is expected to be made in November.

## 3. Background

### 3.1. History

From early 2008 PCTs in London have been preparing to separate their function as commissioners of health care from their function as providers of health care. This is to allow each half to concentrate fully on its own function.

In late 2008 the decision was taken by Ealing PCT and by Harrow PCT (since re-branded as NHS Ealing and NHS Harrow) for their provider arms to become an Autonomous Provider Organisation (APO). This would have a single management team, developing its own governance structures, whilst remaining formally a part of both PCTs. Advantages of this arrangement were seen to include:

- strengthening governance processes,
- sharing good practice across two boroughs,
- retaining a focus on services in each borough and the close working relationships with the borough social care and education services,
- avoiding duplicating costs by establishing two top teams.

Ealing and Harrow Community Services began as an Autonomous Provider Organisation (APO) in April 2009, as a step towards fuller separation. This was done with a desire to keep open the possibility of including services in Brent at some point in the future.

The next step has been to establish a medium and longer term organisational future for these services, which would achieve full separation and launch the community services in an organisation in which they can thrive and develop further. This is the future which is considered in this Options Appraisal.

### 3.2. Structure of the Options Appraisal paper

This paper begins by explaining the **Environmental Factors** which need to be taken into account. (Section 4)

It goes on to set out **Criteria** against which the possible options should be scored. (Section 5)

An explanation of why some options have been discarded is given, and then each remaining **Option** is described in more detail, including the main advantages and disadvantages. (Section 6)

Each option is then S**cored** for against each criteria (Section 7). These scores are added together to give the total scores for each of the main options, the **Results** (Section 8).

There is then a **Sensitivity Analysis**, to examine whether there are factors which if scored or weighted differently would make a material difference to the result. (Section 9)

The paper ends with **Conclusions** (10), **Next Steps** (11), and **Recommendations** (12).

## 4. Environmental Factors

This section sets out the background against which our choices should be made. The Criteria have been strongly influenced by these factors.

### 4.1. Transforming Community Services

A major initiative across the NHS was launched in January 2009 to improve community health services. Central to this is the need to make significant changes in the way that community services are provided. There is a recognition that community services have for too long been left lower down the NHS's priorities, in terms of focus, funding, workforce and service re-design, and yet they are central to achieving a range of important priorities for the whole health and social care system.

Factors important to success in transforming community services have been identified as:

- Strong leadership from senior clinicians and managers
- Involvement of the full range of clinicians, including nurses, therapists and doctors.
- Teams dedicated to facilitating and driving changes
- Strong organisational focus on community services
- Having a portfolio of services which can be organised in line with the six service areas highlighted in the Transforming Community Services programme:
    - Health, Well-being and Reducing Inequalities
    - Acute Care Closer to Home
    - People with Long-Term Conditions
    - Rehabilitation Services
    - Services for Children, Young People and Families
    - End of Life Care
- A focus on workforce – changing how we utilise scarce professionals, and ensuring they are attracted to work in community services.

### 4.2. Developments in the Market for Community Health Services

The market for community health services is anticipated to develop rapidly, with many of these factors:

- More care in the home, rather than in hospital, and more activity in primary care, rather than hospital outpatients
- More interface services being commissioned, such as polyclinics, intermediate care teams, intermediate bedded services, urgent care centres and community assessment and treatment services
- Increasing demand, from an aging population and from population growth in this part of London

- More commissioning of care along a pathway (such as for diabetic care), rather than by specific professional groups in specific settings
- Individual services being put out to tender, to test the market, drive up quality and drive down price
- Some very large tenders for groups of services
- Commissioners deliberately choosing a mixed economy of providers: several NHS providers in one area, plus some private providers and voluntary sector providers.
- The arrival of more niche providers, crossing borough and county boundaries, specialising in particular services.
- The potential for chains operating regionally or nationally, gaining from economies of scale and strengths in bidding and service re-design.
- Consequently, there is a need for providers to be of sufficient size and critical mass to support a strong bidding and service development function, to compete in this more complex and challenging market.
- Providers will in future need to be able to withstand the loss of some parts of their portfolio of services to other providers.

### 4.3. Changes in acute services in north west London

Whilst much is still to become clear, it is anticipated that there will be:

- A reduction in the number of acute hospital organisations, as several are not now expected to proceed to Foundation Trust status alone
- Re-configuration of more specialist acute services, being provided on one site for a large population (e.g. stroke and trauma services)
- Re-configuration of acute services, for example planned surgery being concentrated on fewer sites, or similarly emergency surgery or inpatient pediatrics.
- Consequent changes to patient flows to different hospitals and accident and emergency units
- Hospitals maintaining a full range of outpatient and diagnostic services
- More than one acute provider operating on some major hospital sites

It is not now expected that Ealing Hospital NHS Trust will progress to become a Foundation Trust. It is also clear that Ealing Hospital is not being seen as a hospital which will develop the specialist acute services which are being concentrated on a smaller number of sites. Indeed, there is likely to be a gradual reduction in the range of acute services on that site, and some services at Ealing Hospital may be managed by another trust.

It is not yet clear whether North West London Hospitals NHS Trust will proceed to become a Foundation Trust. However, there are already several specialist acute services on the Northwick Park Hospital site, and this will be the location for the new “hyper acute” stroke centre, one of eight across London.

### 4.4. Changes in Commissioning Organisations in London

PCTs in London have generally stayed at the size of a London borough. They did not go through the changes elsewhere in the country three years ago which moved many PCTs to cover populations of a million or a million and a half people.

The commissioning of acute services in London is increasingly being led by teams covering a whole sector (e.g. inner and outer north west London). Mental health and learning disability services are commissioned jointly with local authorities. PCTs have already moved the management of community services to autonomous providers.

These factors make it more likely that some changes will take place to the configuration of PCTs in London, combining in some way. This factor encourages PCTs to secure the separation from their community services sooner rather than later.

### 4.5. Working with Local Partners on a Borough Basis

Community health services will need to continue to have strong links with other parts of the health and care system locally, and to develop these further.

Local Authorities are key partners in delivering care, whether this is for older people, children and young people, or adults of working age. Other partners include Practice Based Commissioning Groups, voluntary organisations, and patient and public involvement groups. The relationships built up by service managers, senior managers, as well as the ones at a clinical level, will remain very important.

From the formation of Ealing and Harrow Community Services, and when the decisions were made in 2008, there has been a commitment to continue to have a strong borough focus to the delivery of services. So for example, it is not envisaged that the district nursing service would be merged and run across two or three boroughs, but on a borough basis. There are gains to be made from the support teams working across a wider area, for example on developing clinical practice, training, service improvement and governance. Also, for some smaller services, particularly those with a small number of scarce professionals, there may well be moves to join services together across boroughs, where this enables a better service to be provided. But in the main, it is expected that under all the options considered, a strong borough focus will be retained.

Changes in acute hospital provision are anticipated across north west London, together with possible changes to commissioning PCTs.

### 4.6. Children's Services and Local Authorities

There is a potential for continuing the trend towards integration of children's services between the NHS and the social and education services provided by local authorities. If this were to take place, it is likely that this would lead to the transfer of several core community health services into a new body, such as a Children's Trust or a Partnership Trust. This could include health visitors, school nurses and other specialist services for children. Therapy services for children might transfer, or remain part of larger therapy services, with teams working closely with colleagues in integrated services.

At present, there are no strong moves to make such large scale integration in the geographical areas being considered here. It may be that Children's Trusts will develop as integrated commissioning organisations, rather than providers.

However, the potential for such transfers in the longer term needs to be born in mind, so as to not create new health care organisations that would become unviable if this were to happen in the future.

### 4.7. The Financial Outlook

NHS organisations must anticipate considerable constraints on public sector spending in the years ahead. This will bring:

- a greater focus on productivity,
- pressure to reduce unnecessary overheads costs, multiple organisations and duplicate departments
- greater appetite for major service changes
- increased focus on achieving savings through managing demand well
- more moves to re-commission patient pathways
- more use of competitive tendering by commissioners to seek price reductions and quality improvements.

However, this does not mean that there is no scope to increase community services. Instead, increases will need to be based on improved productivity and from transferring funding from other modes of providing care, particularly from hospital care, where there is a shift in where patients receive their care.

This poorer financial outlook will encourage organisations to choose solutions which are likely to give more scope to make savings on their infrastructure costs – be this the cost of having separate organisations each with its own top team, or the cost of several organisations each with their own support service departments.

It also means that being able to withstand reductions in service income has become more important.

## 4.8. Organisational Forms

The Department of Health's policy can be summarised as being that all NHS provider organisations should become either Foundation Trusts or Community Foundation Trusts. For a period of time there will continue to be a dwindling number of NHS Trusts.

Also for a period of time community services can remain as "Directly Provided Organisations" within another NHS body – most likely their originating PCTs. (Note the slight change of terminology from Autonomous Provider Organisation used in London, to Directly Provided Organisation used nationally). In this form, the community services have their own Board, top team and governance processes, but remain accountable to their PCT Board, and staff remain employees of the PCT. However, this Directly Provided Organisation (DPO) option is only seen as temporary, whilst progress is made to another organisational form, unless in exceptional circumstances.

Therefore, any long-term organisational future for community services is likely to involve an interim phase, with a progression to become a Community Foundation Trust or being part of a Foundation Trust. For the purposes of this Options Appraisal it is assumed that it would take two years to make this progression, though it may well take longer.

An alternative form is to become a Social Enterprise. This term is used for a number of legal forms, the most common of which are: Charities, Industrial and Provident Societies, Community Interest Companies and Limited Liability Companies.

Staff have a "right to request" to set up a social enterprise to deliver services. The 'right to request' entitles primary and community care staff to put a business case to their PCT board to set up independent social enterprises and to have their case considered. If approved, the PCT will support the development of the social enterprise and award it a contract to provide services.

In this Options Appraisal, the possibility of moving the whole or most of the community services into a Social Enterprise is considered as an Option. In addition, an individual service or group of services could also move to become a Social Enterprise, whilst the rest of the organisation moved to one of the Options outlined in this Appraisal. So staff using their "right to request" for an individual service or group of services has the same kind of effect in this Options Appraisal as if the service were passed to another provider through the loss of a tender process, or a transfer to another trust.

## 5. Criteria

### 5.1. Explanation

This section describes and explains the nine criteria used to appraise each of the options.

Each criterion has a number of sub-criteria, which are the main aspects that together make up the criterion. The score for each criterion is out of 10, being a combination of how high or low the option rates against the sub-criteria.

An example would be, a Criterion with three sub-criteria rated High-High-High would score 10, High-Medium-Low would score 5, High-High-Low would score 7 etc. Some options may be rated very highly, or very low. A commentary on each sub-criterion is given, to enable a score to be achieved, and to help give more clarity and consistency. It is recognised that in an exercise like this there is a degree of subjectivity in making some of the scores, and this is in the nature of the topics being considered. There are also a range of interpretations and judgements that could be made by different people. As a result, a wide group of people from across the organisation was involved in scoring the options, as described in section 7.

It is the case that sometimes a factor appears in several criteria. An example is the size of the organisation. This affects four criteria: the capacity to transform community services, the ability to provide services beyond Ealing and Harrow, having the revenue to meet the criteria for a community foundation trust, and withstanding losses in income in future. This is not an error or a bias – it simply reflects the reality that some factors drive more than one criteria. However, none of the criteria are entirely dependent on one underlying factor alone.

The Criteria were agreed by the Provider Alliance Board at its August 2009 meeting:

Criterion 1: Full Separation from Commissioners
Criterion 2: Capability to Transform Community Services
Criterion 3: Focus on Transforming Community Services
Criterion 4: Able to improve services beyond Ealing and Harrow
Criterion 5: Attracts Staff to Work in Community Services
Criterion 6: Viability: Balanced Budget; Capital; and Revenue
Criterion 7: Viability: Likely to Grow, and Withstand Losses in Services
Criterion 8: Scope to reduce spending on overheads and inefficiencies
Criterion 9: Meeting Commissioners' Aspirations

### 5.2. The Criteria in detail

**Criterion 1: Full Separation from Commissioners**

This is a policy imperative, to enable PCTs as commissioners to focus on their commissioning function, and to enable provider services to focus on their providing role. The sub-criteria are:

**C1.1 Separation from Both Commissioner PCTs**
This is an aim of the separation process, and all the options achieve this in time. However, some options do this in stages, remaining part of one PCT for a period. This does not allow the full benefits of separation for the provider services or for the host PCT, so such options would logically receive a lower score on this criterion.

**C1.2 Speed of Separation**
Some options achieve separation in April 2010, so would score highly. Others delay this until 2011, scoring medium, or 2012 scoring low.

**Criterion 2: Capability to Transform Community Services**

This is important for the future of patient services (see section 4.1 above). The sub-criteria are:

**C2.1 Large enough to secure the services of key clinical and managerial leaders**
We need leaders recruited for their skills and experience in community services. This will be partly determined by the size of the organisation – being able to attract and afford senior and experienced people. (This will also partly depend on the organisation having a clear focus on community service provision, and the scoring for this aspect is covered in Criterion 3.)

**C2.2 Capable of containing more medical consultant leaders**
Community services already have clinical leaders from nursing and therapy backgrounds at consultant level, and a small number of medical consultants. For some aspects of the transformation agenda, there will also be a need for leadership from consultant medical staff within acute specialisms, in order to achieve change along the patient pathway.

**C2.3 Large enough to justify central teams facilitating and driving transformation**
Achieving sustained changes in services is greatly assisted by having a central team or teams who have the skills and time to support each service in the various stages of planning and implementing changes. Larger organisations will have greater scope to build such teams, and spread their cost across a broader base of services.

**Criterion 3: Focus on Transforming Community Services**

**C3.1 An Organisation Focused on Community Services**

Without a strong focus on these services, there is a much higher likelihood that community services will continue to be given lower priority for attention, for funding and for service change. Organisations exclusively providing community services would score highest on this sub-criterion; those with a large proportion of community services would score highly; those with a smaller proportion would score lower or lowest.

**C3.2 A portfolio of services crossing the acute / community boundary, able to be organised to match the 6 service areas for Transforming Community Services**

Many aspects of service transformation depend on considering the whole pathway of care that a patient is on, rather than a series of distinct services which they access. For this reason the Transforming Community Services programme looks to organisations to group services into six areas and consider the whole pathway:

- Health, Well-being and Reducing Inequalities
- Acute Care Closer to Home
- People with Long-Term Conditions
- Rehabilitation Services
- Services for Children, Young People and Families
- End of Life Care

Including services from both the acute and community sectors together within these groupings would facilitate changes more easily, removing some long-standing obstacles to change.

**C3.3 Likely to achieve transformation and support the Healthcare for London strategy and Darzi aspirations**

This sub-criterion is about the likelihood of achievement of these strategic aims, rather than a question of size or range of services. This scores the organisation on how much delivering these changes will be at the heart of its purpose.

## Criterion 4: Able to improve services beyond Ealing and Harrow

There are two reasons why this Criterion is included. Firstly, where a service is provided well in one area, there is a gain to be made by bringing the benefits of that well run service to the populations of other areas. Secondly, there will be gains from growing the service and financial base of the organisation. These include gaining economies of scale, spreading good practice, and being less vulnerable to destabilising the whole organisation if some services are lost to other providers through competition. The sub-criteria used are:

### C4.1 Likely to take on and improve services in Brent

When the decision to form Ealing and Harrow Community Services was made at the end of 2008, this was done with a desire to keep open the possibility of including services in Brent at some point in the future.

Bringing Brent services together with Harrow and Ealing would build an organisation which covers the whole catchment areas of the two acute hospitals in North West London Hospitals NHS Trust (Northwick Park and Central Middlesex), and Ealing Hospital. This would enable the hospitals to work with a single community services organisation.

Should NHS Brent decide that they wished their provider services to join, then the earliest this is likely to be possible is October 2010.

Those options based on organisations in Ealing and Harrow are the most likely to undertake a link with Brent services, so would score highest. Those based on organisations outside Ealing and Harrow would score less.

### C4.2 Large enough to be able to expand to wider populations

This could either be by taking in whole boroughs, or by expanding individual services to new populations.

This in part depends on being large enough to justify having a business development function with sufficient critical mass to win new tenders, and partly on being able to demonstrate having strength of experience in a wide range of services.

### C4.3 Including some acute services, facilitating expansion to wider populations

Organisations with some acute services within their portfolio would be more likely to be able to be able to win business in new areas where this depends on the ability to work well across the acute / community boundary.

**Criterion 5: Attracts Staff to Work in Community Services**

London has a very competitive labour market. Health professionals are relatively scarce, and the whole ability to provide services and to improve them will depend on the ability to attract and retain good staff. Ealing and Harrow are surrounded by a large number of alternative NHS employers, often within easy travelling distances, and some of which have the advantage of paying higher salaries as a result of being in Inner London. The sub-criteria are:

**C5.1 Offers the NHS Pension Scheme to New Staff**
The NHS Pension Scheme is an important part of the remuneration package for health care staff. NHS organisations will continue to be able to offer this scheme. Staff transferring into a Social Enterprise when it is formed will be able to remain in the NHS Pension Scheme. However, Social Enterprises will not be in a position to offer new employees the chance to join the NHS Pension Scheme, or to continue within it. This is a major disincentive for new employees to join a Social Enterprise. This would result in a very low score.

**C5.2 Continuity of Service is Recognised by NHS Employers**
For some aspects of employment rights, such as calculating redundancy payments, NHS employers recognise continuity of service from one NHS employer to the next. However, NHS employers are not expected to recognise continuity of service when staff move from a Social Enterprise into an NHS employer. This is a disadvantage to staff who are likely to move around from one employer to the next during their career. This would also result in a lower score.

**C5.3 A Good Reputation for Clinical Quality**
This is an important factor for many staff when choosing where they work. It is recognised that to some extent scoring this sub-criterion will inevitably be a matter of judgement, rather than an objective measure.

**C5.4 Focused on Community Services**
In the main, organisations which are clearly focused on providing community services are more likely to be attractive to experienced community staff than alternative employers.

## Criterion 6: Viability: Balanced Budget; Capital; and Revenue

It is important to ensure that any chosen option has a viable long term future. For those Options which do not aim to become a Community Foundation Trust, the final sub-criterion does not apply, so they are treated as meeting that sub-criterion.

### C6.1 Balanced Budget

Where an option involves joining with another organisation, it is important that it is expected to have a balanced budget in the longer term. For this Appraisal, existing Foundation Trusts are presumed to have a balanced budget, and those options just containing EHCS's current services are also presumed to have a balanced budget (as currently).

### C6.2 Has a Source of Capital

Community Foundation Trusts, Foundation Trusts and Social Enterprises all have sources of capital to fund new capital expenditure. However, PCTs have very limited access to new capital, so the option of remaining within a PCT is scored lower.

### C6.3 Meets the Revenue Size Requirements of Becoming a Community Foundation Trust or Foundation Trust (where relevant)

The pilot phase of the Community Foundation Trust (CFT) programme has shown that the regulatory body Monitor seeks new CFTs to have a minimum annual revenue of around £100 million, as they already do for Foundation Trusts. Of all the options considered for scoring, the only two which would fall below this level are those based on the services currently within Ealing and Harrow Community Services, whose turnover would be around £60 million. However, this issue would be removed if there were a substantial increase in services during the period before achieving CFT status – for example by including services for the Brent population (turnover £40+ million). Therefore these two options receive a lower scoring than the others.

As noted above, this sub-criterion is scored as being met by those options involving a Foundation Trust or Social Enterprise as the end point.

**Criterion 7: Viability: Likely to Grow, and Withstand Losses in Services**

This is another aspect of viability.

**C7.1 Likely to Grow, by acquisition or competition, as competitors grow in number and size**

As the market for community services develops, competition is expected to increase, both from new competitors arriving, and as competitors become larger. So an option scoring well against Criterion 4 would also score well on this sub-criterion.

**C7.2 Able to withstand losses of community services**

Such losses could arise from competition for current services or from the deliberate transfer of services to other providers, such as children's services into an integrated service with a local authority. Whilst all the Options are vulnerable to this type of loss, the smaller organisations would be more vulnerable, so scoring lower.

**C7.3 Able to withstand losses of acute services from the Ealing Hospital portfolio (where relevant)**

Clearly, those Options which do not include a relationship with Ealing Hospital would score highly on this. The Integrated Care Organisation option would gain a medium score, as it would still remain viable due to its overall size, should there be some major transfers of acute services either from the Ealing Hospital site or to the management of another acute provider.

**Criterion 8: Scope to reduce spending on overheads and inefficiencies**

This criterion has particular importance in view of the poor financial outlook, and the need to derive as the greatest value for money possible.

**C8.1 Reduces the Number of Organisations**

This is about reducing the cost of having a top team running an organisation, and duplicating the support service departments. Only some of the costs would be saved, but this is still significant. Options score lower where they remain a Directly Provided Organisation (with its own top team) or where they become a separate organisation without joining another. Options resulting in joining another organisation score highly, as this reduces the number of organisations.

**C8.2 Speed of Reducing the Number of Organisations**

Options achieving a reduction in the first year score highest, those taking one year score medium, and those taking two years score low. Those not making a reduction also score low.

**C8.3 Increases the Scope for Cost Reductions in Providing Services**

Options which create an integration across the acute / community boundary score higher on this sub-criterion (though this only applies where the acute and community services both serve the same population). Options which enable economies of scale by joining with other community services also score higher.

**Criterion 9: Meeting Commissioners' Aspirations**

**C9.1 A Provider with an Incentive to Reduce Overall Use of Health Services**

Currently, acute health care providers are paid according to the work they do. They have no incentive to reduce an individual's unnecessary use of health services, since each outpatient appointment and inpatient admission is paid for by the PCT. Commissioners, particularly in Ealing, have an aspiration to create a system where the acute care provider has an incentive to reduce unnecessary usage, plus the means to achieve this through their provision of community services. This would involve commissioners contracting with a provider differently, along the whole pathway of care, rather than using the current tariff system. This is in some ways like a Health Maintenance Organisation in the USA. The Option of an Integrated Care Organisation scores highly on this sub-criterion, while the others score low.

**C9.2 A Provider Capable of Competing with another Local Acute Provider**

A community provider which also included some acute provision would have a greater ability to compete to provide those services that are on the boundary between acute and community care. Those options where the acute provision is closely integrated with community services for the same population would score the highest of all. Those options where the acute provision is in a different area to the community services would score medium.

## 5.3. Weighting the Criteria

Often in an Options Appraisal there is a process of weighting the criteria, as some are viewed as having more priority than others.

For this Options Appraisal, all the criteria will receive equal weight, reflecting equal importance. Therefore the scores will simply be added together to achieve a total score for the option.

However, it should be noted that there are two criteria about Transforming Community Services, and two about Financial Viability. This reflects their importance, and in effect gives a stronger weighting to those two aspects.

Once the scoring has been completed, a sensitivity analysis will be undertaken. This will investigate whether using different weightings would materially affect the result. This can give greater confidence to the conclusions, or point out where the weighting or scoring of a particular factor is having a major impact on the overall result.

## 6. The Options Described

First the options discarded are explained, then the options to be scored are explained, together with their key advantages and disadvantages.

### 6.1. Options Discarded

A number of options have been discarded at an earlier stage. These are included for completeness, with the reasons identified.

**Do nothing**

This option was rejected on the basis that it runs counter to national policy to separate the commissioning parts of each PCT from its provider functions. It also fails to realise many of the advantages of other options.

**Private Sector**

This option was rejected during the 2008 decisions. This was because the PCTs wished to retain a public sector ethos, and not introduce private provision of NHS services on such a large scale for their populations.

**Dispersal to many providers**

This option was rejected during the 2008 decisions. This was because of the benefits of synergy between many of the community services, and also to retain services with a strong borough focus, which would be lost if the services were dispersed.

**Primary Care Organisation**

This option was rejected during the 2008 decisions. This was because the GP / Practice Based Commissioning organisations were regarded as being insufficiently developed to run the scale of organisation being considered. This is still the current position.

### 6.2. Options to be Scored

The following six Options have been considered, and proceed to be scored.

As explained previously, almost all options involve two phases, an interim phase progressing to a final organisational form.

They are described in more detail in the next section, together with their key advantages and disadvantages.

Option A A Directly Provided Organisation within Ealing PCT,
becoming a Community Foundation Trust

Option B A Directly Provided Organisation within Ealing PCT,
becoming a Social Enterprise

Option C A Directly Provided Organisation within another Trust,
becoming a Community Foundation Trust

Option D Join a Major Acute Trust
becoming part of a Foundation Trust

Option E Create an Integrated Care Organisation
becoming a Community Foundation Trust

Option F Join Another Community Services Provider
becoming a Community Foundation Trust

### 6.3. Description of each Option to be Scored

**Option A A Directly Provided Organisation within Ealing PCT, becoming a Community Foundation Trust**

**Description**

Under Option A, the community services would continue to be run by a single management team, as a Directly Provided Organisation within a PCT – the option most like the current arrangements.

In April 2010 staff would transfer from Harrow PCT to Ealing PCT.

The aim would be to establish a new Community Foundation Trust (CFT), for April 2012, after two years.

**Key Advantages**

- Creates an immediate separation from one of the commissioners: NHS Harrow.
- Very focused on community services
- More likely to take on services in Brent, as locally focused and has an incentive to expand to ensure viability
- More likely to attract staff, as an NHS organisation with full NHS Pension availability and continuity of service.
- More likely to attract staff, having a good reputation, and clearly being focused on community services.

**Key Disadvantages**

- Separation from commissioners in NHS Ealing is delayed for 2 years.
- Not containing acute medical consultants, and not crossing the acute / community boundary, so less opportunity for transformational change and less likely growth in services.
- Relatively small at around £60 million. Therefore:
- Less likely to secure the services of clinical and managerial leaders to lead transformational change.
- Less likely to justify the central teams to facilitate and drive transformational change.
- Less likely to win tenders because less likely to justify having a strong business function, and less demonstration of depth of service experience.
- More vulnerable should it lose community services to other providers.
- Not likely to meet the size criteria to become a Community Foundation Trust, which appears to be around £100 million, unless a significant expansion in services – such as including Brent services.
- Limited access to capital while part of a PCT.
- Does not reduce the number of organisations.
- Less scope to reduce costs of services through integration or scale.
- Does not meet commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, nor creating a strong competitor for other local acute providers.

## Option B A Directly Provided Organisation within Ealing PCT, becoming a Social Enterprise

**Description**

Under Option B, the community services would continue to be run by a single management team, as a Directly Provided Organisation within a PCT – the option most like the current arrangements.

In April 2010 staff would transfer from Harrow PCT to Ealing PCT.

The aim would be to establish a new Social Enterprise for April 2012, after two years.

**Key Advantages**

- Creates an immediate separation from one of the commissioners: NHS Harrow.
- Very focused on community services.
- More likely to take on services in Brent, as locally focused and has an incentive to expand to ensure viability.
- Has access to capital once a Social Enterprise.

**Key Disadvantages**

- Separation from commissioners in NHS Ealing is delayed for 2 years.
- Does not reduce the number of organisations.
- Strong factor against attracting staff, as not an NHS organisation, so unable to offer the NHS Pension Scheme to new staff, and those leaving would not take continuity of service with them (see fuller explanation under Criterion 5 above).
- Not containing acute medical consultants, and not crossing the acute / community boundary, so less opportunity for transformational change and less likely growth in services.
- Relatively small at around £60 million. Therefore:
- Less likely to secure the services of clinical and managerial leaders to lead transformational change.
- Less likely to justify the central teams to facilitate and drive transformational change.
- Less likely to win tenders because less likely to justify having a strong business function, and less demonstration of depth of service experience.
- More vulnerable should it lose community services to other providers.
- Limited access to capital while part of a PCT.
- Less scope to reduce costs of services through integration or scale.
- Does not meet commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, nor creating a strong competitor for other local acute providers.

## Option C A Directly Provided Organisation within another Trust, becoming a Community Foundation Trust

**Description**

Under Option C, the community services would continue to be run by a single management team, as a Directly Provided Organisation, similar to the current arrangements.

Staff would transfer from Harrow PCT and from Ealing PCT into another Trust. This could be one of the mental health trusts serving Ealing or Harrow. However, this option would require more time to engage with a host organisation who has not been part of the discussions so far, there would be a delay until 2011.
The aim would be to establish a new Community Foundation Trust (CFT), for April 2012, after two years.

**Key Advantages**

- Focused on community services, but within an organisation focused on other services.
- Likely to wish to take on services in Brent, as has an incentive to expand to ensure viability
- More likely to attract staff, as an NHS organisation with full NHS Pension availability and continuity of service.
- Would have access to capital whilst part of a host trust.

**Key Disadvantages**

- Separation from both commissioners takes place after one year.
- Likelihood of attracting staff may be reduced while being hosted by an organisation focused on other services.
- Would not contain acute medical consultants, and not cross the acute / community boundary, so less opportunity for transformational change and less likely growth in services.
- Relatively small at around £60 million. Therefore:
- Less likely to secure the services of clinical and managerial leaders to lead transformational change.
- Less likely to justify the central teams to facilitate and drive transformational change.
- Less likely to win tenders because less likely to justify having a strong business function, and less demonstration of depth of service experience.
- More vulnerable should it lose community services to other providers.
- Not likely to meet the size criteria to become a Community Foundation Trust, which appears to be around £100 million, unless a significant expansion in services – such as including Brent services.
- Does not reduce the number of organisations.
- Less scope to reduce costs of services through integration or scale.
- Does not meet commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, nor creating a strong competitor for other local acute providers.

## Option D Join a Major Acute Trust becoming part of a Foundation Trust

### Description

Under Option D, the community services would become a part of a major acute trust outside Ealing and Harrow. The most likely organisations are North West London Hospitals NHS Trust (serving Harrow, Brent and parts of Ealing), and Imperial College Healthcare NHS Trust (also serving parts of Ealing).

Staff would transfer from Harrow PCT and from Ealing PCT into the trust. However, this option would require more time to engage with such a trust, which has not been part of the preparatory discussions so far, so there would be a delay, probably until 2011. The end result would be being part of a Foundation Trust.

### Key Advantages

- Reduces the number of organisations, though after one year.
- More likely to attract staff, as an NHS organisation with full NHS Pension availability and continuity of service.
- Would have access to capital whilst part of an acute trust.
- Would contain acute medical consultants, so more opportunity for transformational change and more likely growth in services.
- More likely to secure the services of clinical and managerial leaders to lead transformational change, because of scale.
- Crossing the acute / community boundary for the same population, so more opportunities for transformational change.
- More likely to justify the central teams to facilitate and drive transformational change.
- More likely to win tenders because able to gain from a strong business function, and more demonstration of depth of service experience.
- More likely to expand to other populations, those already served by the trust for acute care.
- More likely to wish to take on services in Brent, if North West London Hospitals NHS Trust.
- Less vulnerable should it lose community services to other providers.
- Goes some way to meeting commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, and creating a strong competitor for other local acute providers

### Key Disadvantages

- Separation from both commissioners takes place after one year.
- Not an organisation focused on community services
- Less likely to wish to take on services in Brent, if Imperial.
- North West London Hospitals NHS Trust is financially challenged.
- Less likely to attract staff as not an organisation focused on community services.
- Less scope to reduce costs of services through scale of community provision.

## Option E Create an Integrated Care Organisation becoming a Community Foundation Trust

**Description**
Under Option E, the community services would join with services from Ealing Hospital Trust, and create a new organisation, as an Integrated Care Organisation.

This new organisation would use the formal organisation that is already established as Ealing Hospital NHS Trust, changing its name and some of its objects (its legal purpose).

Staff would transfer from Harrow PCT and from Ealing PCT into this trust in April 2010.

Those acute services within the Integrated Care Organisation would include the main medical specialties. These offer the greatest scope for integration with community services, and consequently enabling more service transformation. Examples include Diabetes, COPD and Care of Older People.

Some major parts of the acute services would be envisaged to transfer to another acute provider, at a time yet to be determined. Some of these would remain on the Ealing Hospital site, managed by the other acute provider. As in the other options, some, particularly the more specialised acute services, would over time transfer to other sites.

Residents of Ealing would be able to access the full range of services provided by the Integrated Care Organisation. Residents of Harrow would continue to access acute services at Northwick Park Hospital. As the organisation develops, it would aim to provide a wider range of services in Harrow, and potentially Brent.

The organisation would progress to become a Community Foundation Trust.

**Key Advantages**

- Achieves full separation from both commissioners immediately.
- An organisation focused on community services (though less than an exclusively community provider).
- More likely to secure the services of clinical and managerial leaders to lead transformational change, because of scale.
- Would contain acute medical consultants, so more opportunity for transformational change and more likely growth in services.
- Having a portfolio of services crossing the acute / community boundary, so more able to deliver service transformation.
- More likely to justify the central teams to facilitate and drive transformational change.

- More likely to attract staff, as an NHS organisation with full NHS Pension availability and continuity of service.
- More likely to attract staff as an organisation focused on transforming community services.
- More likely to win tenders because able to demonstrate integration of care across the acute / community boundary
- More likely to win tenders from a strong business function
- More likely to take in services in Brent.
- More likely to be able to expand to other populations
- Less vulnerable should it lose community services to other providers.
- Reduces the number of organisations immediately.
- More scope to reduce costs of services through integration.
- Meets commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, and meets commissioners' aspirations to create a strong competitor for other local acute providers
- Would have access to capital whilst part of an existing trust.
- Meets revenue size requirements to become a Community Foundation Trust (£100 million) as even with significant transfers of acute services to another provider, turnover would be £120million.

**Key Disadvantages**

- Less focused on community services than an exclusively community provider.
- Some challenges to achieve a balanced budget as acute services transfer to another provider. This aspects merits further clarity.
- Less scope to reduce costs of services through having a larger scale of community provision (though this changes if Brent services become included).

## Option F Join Another Community Services Provider becoming a Community Foundation Trust

### Description

Under Option F, the community services would transfer to another NHS community services provider.

Staff would transfer from Harrow PCT and Ealing PCT to the other community services provider. This would take place in April 2011, because of the time needed to commence dialogue with other providers, and reach a decision.

The aim would be that they would establish a new Community Foundation Trust (CFT), for April 2012, after a further year

### Key Advantages

- Very focused on community services
- Larger organisation (perhaps £150 million)
- More likely to secure the services of clinical and managerial leaders to lead transformational change.
- More likely to justify the central teams to facilitate and drive transformational change.
- More likely to win tenders because less likely to justify having a strong business function, and less demonstration of depth of service experience.
- More likely to attract staff, as an NHS organisation with full NHS Pension availability and continuity of service.
- More likely to attract staff, being clearly focused on community services.
- Less vulnerable should it lose community services to other providers.
- Meets the size criteria to become a Community Foundation Trust, which appears to be around £100 million.
- Reduces the number of organisations after one year.
- More scope to reduce costs of services through scale.

### Key Disadvantages

- Separation from both commissioners is delayed by a year.
- Less likely to take on services in Brent, as not locally focused and has less incentive to expand to ensure viability
- Not containing acute medical consultants, and not crossing the acute / community boundary, so less opportunity for transformational change and less likely growth in services.
- Limited access to capital while part of a PCT.
- Less scope to reduce costs of services through integration.
- Does not meet commissioners' aspirations for an acute provider with an incentive to reduce overall use of services, nor creating a strong competitor for other local acute providers.

## 7. Scoring

### 7.1. Scoring system

Some of the paragraphs from the Criteria section are repeated here for convenience.

Each criterion has a number of sub-criteria, which are the main aspects that together make up the criterion. The score for each criterion is out of 10, being a combination of how high or low the option rates against the sub-criteria.

An example would be, a Criterion with three sub-criteria rated High-High-High would score 10, High-Medium-Low would score 5, High-High-Low would score 7 etc. Some options may be rated very highly, or very low. Thus an overall score for the Criterion is created.

It is recognised that in an exercise like this there is a degree of subjectivity in making some of the scores, and this is in the nature of the topics being considered. There are also a range of interpretations and judgements that could be made by different people. As a result, a wide group of people from across the organisation was involved in scoring the options, as described below.

### 7.2. The Scoring Event

An event was convened on 7 September 2009, to involve and benefit from the experience and judgement of a wide range of people who know the services well and are experienced in running community health services.

Invitations were sent to the staff side representatives, members of the Leaders Forum – a group of about seventy leaders from across the organisation – plus an invitation to each team to send a member if they wished. Although there was relatively short notice, 58 people attended the afternoon and early evening session, with a good mix across services and a mix of managers, clinical leaders and team members.

A series of presentations were given, explaining the purpose and process and then the environmental factors shown in this paper. Each of the options was explained, and the criteria explained. Questions were taken at each stage, to help the group of staff gain as full an appreciation of the issues as possible, plus time for informal discussion.

Towards the end of the scoring event, those present (except the directors, managing director and the chair of the board) individually scored each option against the four criteria on which it was thought staff would be most able to give an informed view. These were criteria 2 to 5.

Criteria 1 and 6-9 were been scored by the directors, as some of the criteria are very mechanistic, with little room for judgement (e.g. the degree and speed of separation; and the Financial Viability balanced budget, capital and revenue; and meeting commissioners' aspirations), or needed a specifically managerial judgement.  This was also a matter of practicality, as explaining and scoring all the criteria would have taken a full day. The scores set by the directors were not displayed until after the staff had done their scoring, to avoid this having any effect.

A range of views were expressed during the question and answer sections. Some people clearly wished the process was more mathematical and definite, with each aspect proven and determined, while others did not wish to be forced down a mechanistic process without the ability to use their judgement.

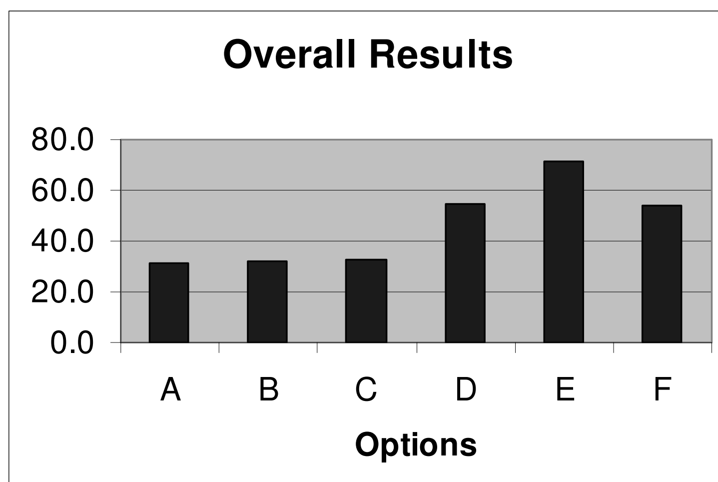
It was made clear that whilst they could discuss their thoughts with people on their table, and use the information from the presentations, people were to complete their score sheet individually, and use their own judgement of the sub-criteria, and how they should be combined to create a score out of 10 for each criterion for each option ( 10 being the most positive ).

At the end of the event, the results were fed back to the whole group, so everyone could see the scores that had been given, and their combined effect.

## 8. Results

The following scores were recorded. A fuller table showing the information in more detail, plus graphs, follows this table.

| Option | Option A | Option B | Option C | Option D | Option E | Option F |
|---|---|---|---|---|---|---|
| 1 Full Separation from Commissioners | 4 | 4 | 6 | 6 | 10 | 6 |
| 2 Capability to Transform Community Services | 3.1 | 3.3 | 3.5 | 6 | 7.2 | 5.9 |
| 3 Focus on Transforming Community Services | 4.2 | 4.2 | 4.2 | 4.4 | 7.7 | 5.7 |
| 4 Able to improve services beyond Ealing and Harrow | 3.7 | 3.7 | 4.0 | 6.3 | 7.6 | 5.8 |
| 5 Attracts Staff to Work in Community Services | 7.2 | 3.5 | 4.7 | 4.8 | 6.0 | 6.9 |
| 6 Viability: Balanced Budget; Capital; and Revenue | 3 | 7 | 4 | 7 | 7 | 8 |
| 7 Viability: Likely to Grow, and Withstand Losses in Services | 3 | 3 | 3 | 9 | 7 | 9 |
| 8 Scope to reduce spending on overheads and inefficiencies | 2 | 2 | 2 | 6 | 9 | 6 |
| 9 Meets Commissioners' Aspirations | 1 | 1 | 1 | 5 | 10 | 1 |
| Total | 31.2 | 31.7 | 32.4 | 54.5 | 71.4 | 54.1 |




This shows a clear result in favour of Option E, the Integrated Care Organisation.

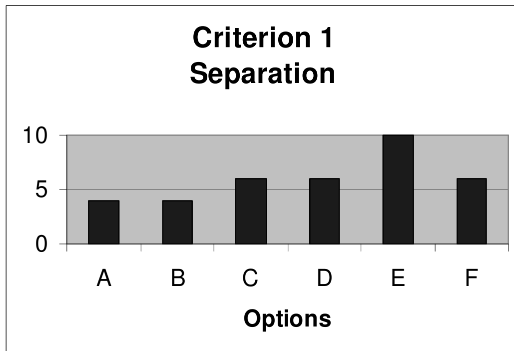
The next highest option is option D, joining a Major Acute Trust, closely followed by option E, joining Another Community Provider.

All three options involving remaining a Directly Provided Organisation score very similarly.

# EHCS Organisational Future - Options Appraisal Scoring Sheet

| Option | Option A | | Option B | | Option C | | Option D | | Option E | | Option F | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Title | A Directly Provided Organisation within Ealing PCT, becoming a Community Foundation Trust | | A Directly Provided Organisation within Ealing PCT, becoming a Social Enterprise | | A Directly Provided Organisation within another trust, becoming a Community Foundation Trust | | Join a Major Acute Trust, becoming a Foundation Trust | | An Integrated Care Organisation, becoming a Community Foundation Trust | | Join another community services provider, becoming a Community Foundation Trust | |
| Stages | Harrow PCT staff transfer to Ealing PCT 2010<br>All transfer to CFT created 2012+ | | Harrow PCT staff transfer to Ealing PCT 2010<br>All transfer to SE created 2012+ | | Harrow PCT and Ealing PCT staff transfer to another trust 2011.<br>All transfer to CFT created 2012+ | | Harrow PCT and Ealing PCT staff transfer to major acute trust 2011. | | Harrow PCT and Ealing PCT staff transfer to ICO, formally EHT 2010.<br>CFT created 2012+ | | Harrow PCT and Ealing PCT staff transfer to another provider 2010.<br>Becomes CFT depending on existing progress. | |
| **1 Full Separation from Commissioners**<br>1.1 Separation from Both Commissioner PCTs<br>1.2 Speed of Separation | 1.1 Stays with 1 PCT.<br>1.2 2 years for full separation | 4 | 1.1 Stays with 1 PCT.<br>1.2 2 years for full separation | 4 | 1.1 Separation from Both.<br>1.2 After 1 year | 6 | 1.1 Separation from Both.<br>1.2 After 1 year | 6 | 1.1 Separation from Both.<br>1.2 Immediate | 10 | 1.1 Separation from Both.<br>1.2 After 1 year | 6 |
| **2 Capability to Transform Community Services**<br>2.1 Large enough to secure the services of key clinical and managerial leaders<br>2.2 Capable of containing more medical consultant leaders<br>2.3 Large enough to justify central teams facilitating and driving transformation. | 2.1 Small (£60 million)<br>2.2 Limited medical leadership<br>2.3 Small | 3.1 | 2.1 Small (£60 million)<br>2.2 Limited medical leadership<br>2.3 Small | 3.3 | 2.1 Small (£60 million)<br>2.2 Limited medical leadership<br>2.3 Small | 3.5 | 2.1 Largest<br>2.2 Includes medical leadership<br>2.3 Largest | 6 | 2.1 Large<br>2.2 Integrated medical leadership<br>2.3 Large | 7.2 | 2.1 Large<br>2.2 Limited access to medical leadership<br>2.3 Large | 5.9 |
| **3 Focus on Transforming Community Services**<br>3.1 An organisation focused on community services<br>3.2 Portfolio of services crossing the acute / community boundary, matching the 6 TCS areas<br>3.3 Likely to achieve transformation and support the Healthcare for London strategy and Darzi aspirations | 3.1 Very focused<br>3.2 Not across acute / community<br>3.3 Less Likely | 4.2 | 3.1 Very focused<br>3.2 Not across acute / community<br>3.3 Less Likely | 4.2 | 3.1 Very focused<br>3.2 Not across acute / community<br>3.3 Less Likely | 4.2 | 3.1 Not focused<br>3.2 Across acute / community<br>3.3 Medium Likely | 4.4 | 3.1 Very Focused<br>3.2 Across acute / community<br>3.3 Strong Likelihood | 7.7 | 3.1 Very Focused<br>3.2 Not across acute / community<br>3.3 Medium Likelihood | 5.7 |
| **4 Able to improve services beyond Ealing and Harrow**<br>4.1 Likely to take on and improve services in Brent.<br>4.2 Large enough to expand to wider populations<br>4.3 Including some acute services, facilitating expansion to wider populations. | 4.1 Likely on Brent<br>4.2 Small<br>4.3 Not acute | 3.7 | 4.1 Likely on Brent<br>4.2 Small<br>4.3 Not acute | 3.7 | 4.1 Likely on Brent<br>4.2 Small<br>4.3 Not acute | 4.0 | 4.1 Likely on Brent (less if Imperial)<br>4.2 Largest<br>4.3 Contains acute | 6.3 | 4.1 Very likely on Brent<br>4.2 Large<br>4.3 Contains acute | 7.6 | 4.1 Likely on Brent<br>4.2 Large<br>4.3 Not including acute | 5.8 |

| Option | Option A | | Option B | | Option C | | Option D | | Option E | | Option F | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **5 Attracts Staff to Work in Community Services**<br>5.1 Offers NHS Pension Scheme to new staff<br>5.2 Continuity of service is recognised by NHS employers<br>5.3 Good reputation for Clinical Quality<br>5.4 Focused on Community Services | 5.1 NHS Pension fully available<br>5.2 Continuity recognised<br>5.3 Medium reputation<br>5.4 Very focused | 7.2 | 5.1 No NHS Pension for new staff<br>5.2 Continuity not recognised<br>5.3 Medium reputation<br>5.4 Very focused | 3.5 | 5.1 NHS Pension fully available<br>5.2 Continuity recognised<br>5.3 Reputation unknown<br>5.4 Not appearing focused | 4.7 | 5.1 NHS Pension fully available<br>5.2 Continuity recognised<br>5.3 Reputation unknown<br>5.4 Not focused | 4.8 | 5.1 NHS Pension fully available<br>5.2 Continuity recognised<br>5.3 Lower reputation<br>5.4 Appears medium focused | 6.0 | 5.1 NHS Pension fully available<br>5.2 Continuity recognised<br>5.3 Reputation unknown<br>5.4 Very focused | 6.9 |
| **6 Viability: Balanced Budget; Capital; and Revenue**<br>6.1 Balanced Budget<br>6.2 Has source of Capital<br>6.3 Meets Revenue Size requirements of becoming a Community Foundation Trust (where relevant) | 6.1 Balanced Budget<br>6.2 Limited capital while in PCT<br>6.3 £60 million) Dependent on growth in services (egg Brent) | 3 | 6.1 Balanced Budget<br>6.2 Limited capital while in PCT<br>6.3 Not applicable | 7 | 6.1 Balanced Budget presumed<br>6.2 Capital available inside a trust<br>6.3 £60 million) Dependent on growth in services (eg Brent) | 4 | 6.1 If NWLHT, financially challenged<br>6.2 Capital available inside a trust<br>6.3 Not applicable | 7 | 6.1 Challenges to Balanced Budget may arise as acute services transfer out<br>6.2 Capital available inside a trust<br>6.3 £120-£160million meets criterion | 7 | 6.1 Balanced Budget presumed<br>6.2 Limited capital while in a PCT<br>6.3 Meets criterion | 8 |
| **7 Viability: Likely to Grow, and Withstand Losses in Services**<br>7.1 Likely to Grow, by acquisition or competition, as competitors grow in size and number<br>7.2 Able to withstand losses of community services<br>7.3 Able to withstand losses of acute services from the Ealing Hospital portfolio (where relevant) | 7.1 Low, see Criterion 4<br>7.2 Vulnerable to losses<br>7.3 Not applicable | 3 | 7.1 Low, see Criterion 4<br>7.2 Vulnerable to losses<br>7.3 Not applicable | 3 | 7.1 Low, see Criterion 4<br>7.2 Vulnerable to losses<br>7.3 Not applicable | 3 | 7.1 High, see Criterion 4<br>7.2 Little Vulnerability to losses<br>7.3 Not applicable | 9 | 7.1 High, see Criterion 4<br>7.2 Medium Vulnerability to losses<br>7.3 Medium Vulnerability to acute losses | 7 | 7.1 High, see Criterion 4<br>7.2 Little Vulnerability to losses<br>7.3 Not applicable | 9 |
| **8 Scope to reduce spending on overheads and inefficiencies**<br>8.1 Reduces the Number of Organisations<br>8.2 Speed of Reduceing the Number of Organisations<br>8.3 Increases the scope for cost reductions in providing services | 8.1 No reduction<br>8.2 Not applicable<br>8.3 Little scope | 2 | 8.1 No reduction<br>8.2 Not applicable<br>8.3 Little scope | 2 | 8.1 No reduction<br>8.2 Not applicable<br>8.3 Little scope | 2 | 8.1 Reduction<br>8.2 After 1 year<br>8.3 Strong scope from integration acute, though not with community unless expansion | 6 | 8.1 Reduction<br>8.2 Immediate<br>8.3 Strong scope from integration acute, though not with community unless expansion | 9 | 8.1 Reduction<br>8.2 After 1 year<br>8.3 Strong scope from integration community, though not with acute | 6 |
| **9 Meets Commissioners' Aspirations**<br>9.1 A provider with an incentive to reduce overall use of health services<br>9.2 A provider capable of competing with another local acute provider | 9.1 No, does not include acute provider<br>9.2 No, does not include acute provider | 1 | 9.1 No, does not include acute provider<br>9.2 No, does not include acute provider | 1 | 9.1 No, does not include acute provider<br>9.2 No, does not include acute provider | 1 | 9.1 Scope with NWL, though less if Imperial<br>9.2 Strengthens one of two providers (Imperial or NWL), rather than strengthening a third competitor | 5 | 9.1 Greatest scope to develop a new model<br>9.2 Most able to be a strong competitor to NWL and Imperial | 10 | 9.1 No, does not include acute provider<br>9.2 No, does not include acute provider | 1 |
| | | 31.2 | | 31.7 | | 32.4 | | 54.5 | | 71.4 | | 54.1 |


Criterion 1
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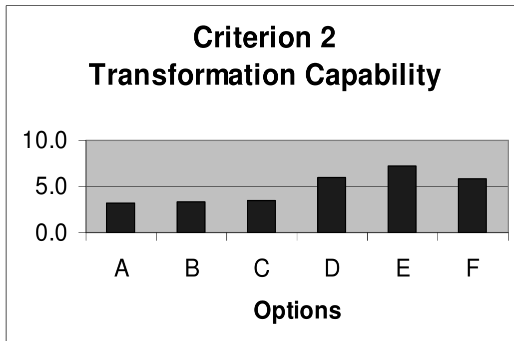
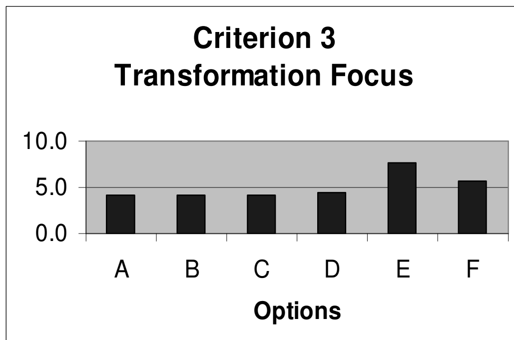
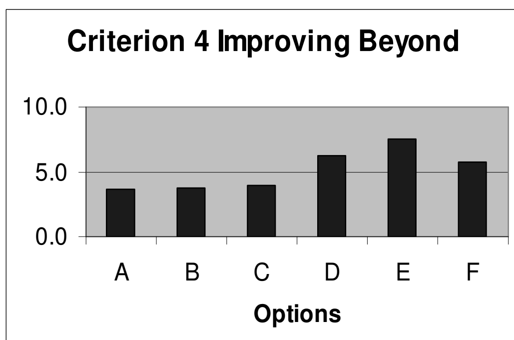
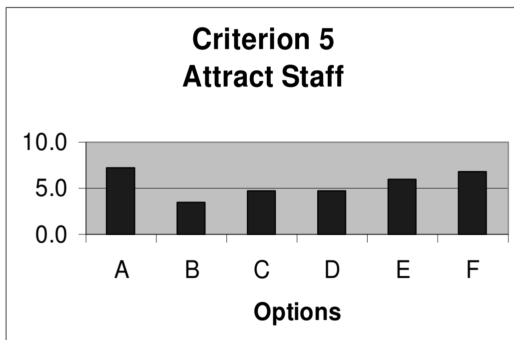
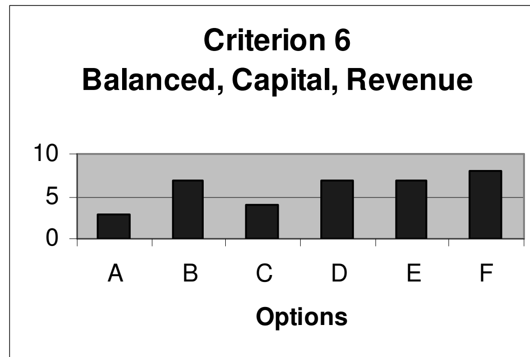
A B C D E F
Options

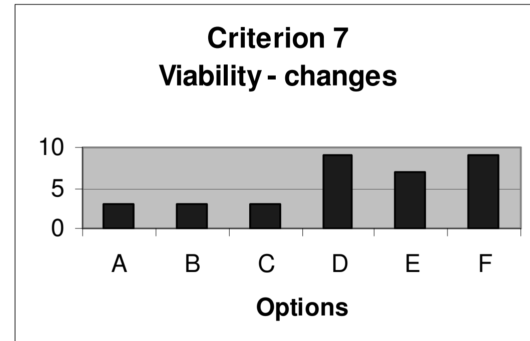

Criterion 2
Transformation Capability
10.0
5.0
0.0
A B C D E F
Options

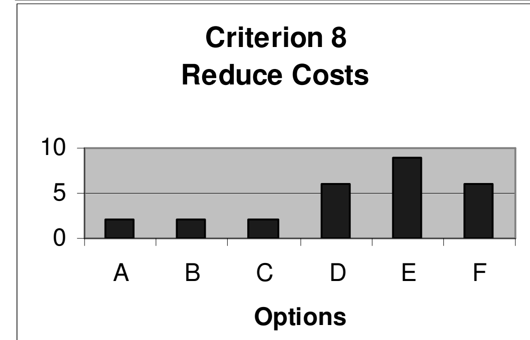

Criterion 3
Transformation Focus
10.0
5.0
0.0
A B C D E F
Options

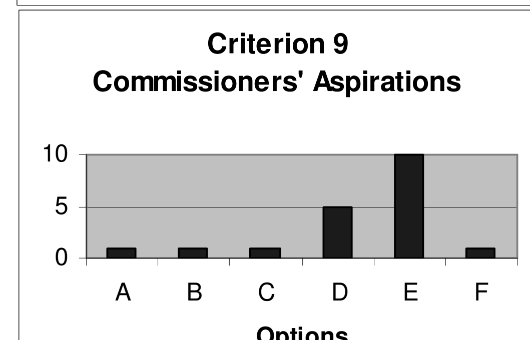

Criterion 4 Improving Beyond
10.0
5.0
0.0
A B C D E F
Options

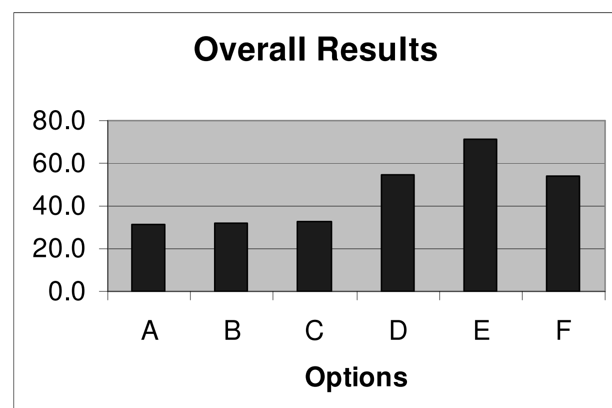

Criterion 5
Attract Staff
10.0
5.0
0.0
A B C D E F
Options


Criterion 6
Balanced, Capital, Revenue
10
5
0
A B C D E F
Options


Criterion 7
Viability - changes
10
5
0
A B C D E F
Options


Criterion 8
Reduce Costs
10
5
0
A B C D E F
Options


Criterion 9
Commissioners' Aspirations
10
5
0
A B C D E F
Options


Overall Results
80.0
60.0
40.0
20.0
0.0
A B C D E F
Options

Two further questions were asked at the Scoring Event, designed to gain more information.

The first was:

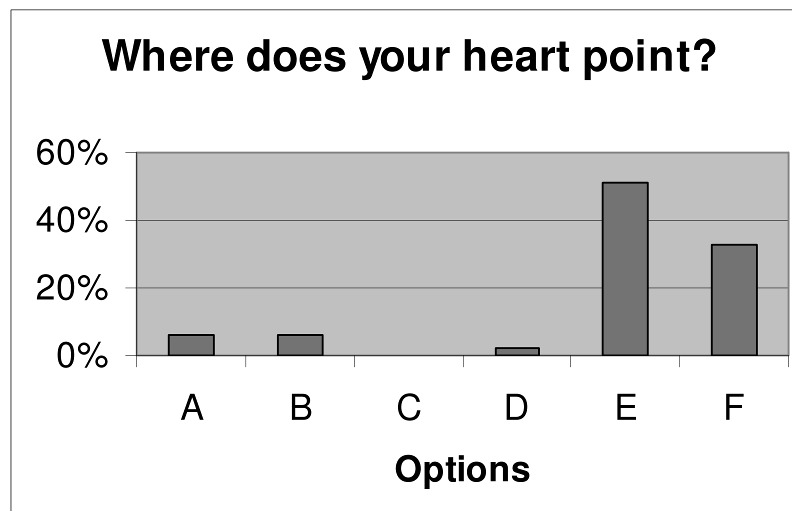
> *In London's competitive labour market, how much do you think it would put off staff if new staff could not join the NHS Pension Scheme, and if other employers did not recognise continuity of NHS service?*
> *Score from 1 to 10, with 10 = No Effect, 1 = Very Serious.*

The staff gave an average score of 1.8. This shows that the staff view this to be a very significant issue in attracting staff in the future.

The second was:

> *Putting aside the analytical side of this Options Appraisal, which option does your heart point you to?*

The results were:



## 9. Sensitivity Analysis

In this section of an options appraisal, the results are tested to discover whether there are factors which, if changed or taken to an extreme, would materially affect the results. This allows the decision to be made in the full light of these factors.

Option E achieved the highest score against all of the criteria except 5, 6 and 7, where option E's score is within 2 points of the highest option. This means that factors would need to change a great deal for the overall result to change, as can be seen below.

**Changing the scores**
For option E to cease to be the top scoring option, it would be necessary to deduct 2 from its score on every criterion.

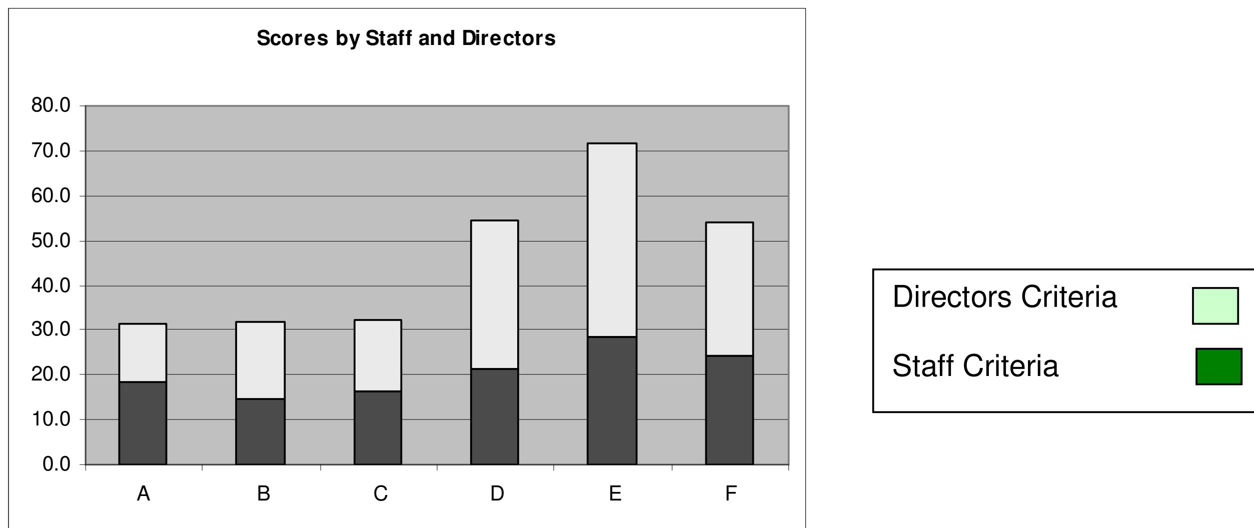
**Weighting the criteria**
The criteria are currently all weighted equally. If the criteria were to be weighted, criteria 5, 6 and 7 would all have to be weighted as 6 times more important than all the other criteria before Option E ceased to be the top scoring option.

**Removing some criteria altogether**
If the three criterion with the greatest difference in scores were removed - criteria 1, 8 and 9 - then Option E still scores highest.

**Criteria scored by staff and directors**
If all the criteria scored by the staff were removed (criteria 2-5), Option E would still be the highest.

If all the criteria scored by the directors were removed (criteria 1,6-9), Option E would still be the highest.

This is illustrated in the graph below:



## Staff from Ealing and Harrow

When the score sheets were collated, the only information about the person scoring that was collected was whether they worked in Ealing, or in Harrow.
7 said they either worked in both or did not say. Care should be taken, as these are not a representative sample, and we are dealing with small numbers of staff. There was an appropriate balance in the proportions of staff: 60% from Ealing and 40% from Harrow.

In the main there was little variation between the scores given by Ealing and Harrow staff. For more than half the scores given, there was less than half a point difference between the Ealing average and the Harrow average.

Scores where difference in the averages exceeded 1.5 are:

- Ealing staff rated Options D and E more highly on criterion 2 (transformation capability) (6.9 to 5.2 and 7,8 to 6.3).
- Ealing staff rated Option E much more highly on criterion 3 (transformation focus) ( 8.2 compared to 5.2).
- Ealing staff rated Option E more highly on Criterion 4 (beyond Ealing and Harrow) (6.6 to 5.0).
- Consequently, the two groups' total scores for each option were within 0.5 of a point of each other for all options except Options D and E, where Ealing scored them both higher (22.5 to 18.5 and 29.3 to 22.8).

Option E would have been the highest even if only the views of Harrow staff were included.

On the question of where does your heart point, the scores were largely similar. The exception is that a smaller proportion of Harrow staff pointed to Option E (30%) compared to Ealing staff (52%), with 15% of Harrow staff pointing to Option B, whilst no Ealing staff did. The effect is that Harrow staff scored Option F higher at 35% compared to Option E at 30%. All those who did not state where they worked, or who worked in both, pointed to Option E.

## Conclusion of the sensitivity analysis

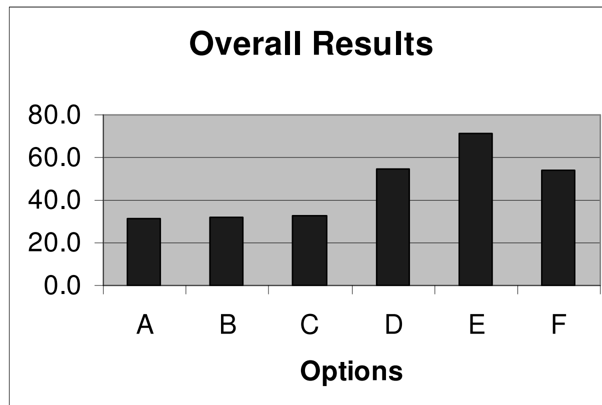
Whichever way the scores or weights or criteria were altered in the sensitivity analysis (even to some rather unreasonable extremes), option E continued to be the option scoring the highest.

## 10. Conclusions

Option E, the Integrated Care Organisation, was the highest scoring option, by a considerable margin. The second and third options were joining a major acute trust (option D) and joining another community provider (option E).

Option E scored highest against six of the nine criteria, and was not far behind on the other three criteria.

The sensitivity analysis found that whichever way the scores or weights or criteria were altered (even to some rather unreasonable extremes), option E continued to be the option scoring the highest.




## 11 Next Steps

The results of this Options Appraisal are considered by the Provider Alliance Board, to make a recommendation to the Boards of NHS Harrow and NHS Ealing.

A more detailed business case for creating an Integrated Care Organisation will be prepared, for consideration by the two PCT Boards, and the Ealing Hospital NHS Trust Board, at their respective meetings in October or November.

If the decision is taken to create the Integrated Care Organisation, then a detailed implementation plan will be created with the aim of making the change on 1 April 2010. This would include formal consultation with staff on the transfer of employment from the two PCTs.

It is not envisaged that this change would require a formal public consultation, as it is a change in the organisations, rather than a major change in services to patients.

A process of due diligence would also take place to ensure all parties are assured of the status and risks involved in making the transfer.

## 12 Recommendation

This is that :

> The Provider Alliance Board agrees to recommend to the Boards of NHS Harrow and NHS Ealing the creation of an Integrated Care Organisation, preferably from April 2010, by the transfer of services and staff into Ealing Hospital NHS Trust, on the basis that there will be a new name and changes to its legal purposes to reflect its new role.

*This recommendation was agreed at the meeting of the Provider Alliance Board of Ealing and Harrow Community Services on 16 September 2009.*

Jonathan Carmichael
Associate Director of Strategy & Business Innovation
Ealing and Harrow Community Services
September 2009

# ATTACHMENT 3

**Current Services Provided by Ealing Hospital Trust (EHT) and Ealing and Harrow Community Services (EHCS)**

## a) EHT Services

| | |
|---|---|
| Acute Medicine | Anaesthetics |
| Anticoagulation | Breast Care |
| Cardiology | Care of the elderly |
| Clinical Haematology | Colposcopy |
| Critical Care | Dermatology |
| Diabetic Medicine | Endocrinology |
| ENT | G.U. Medicine |
| Gastroenterology | General Medicine |
| General Surgery | Gynaecology |
| Infectious Diseases | Neurology |
| Obstetrics | Paediatrics |
| Pain Management | Pathology |
| Radiology | Respiratory Medicine |
| Rheumatology | SCBU |
| Stroke Unit | Surgical Appliances |
| Trauma & Orthopaedics | Urology |
| Vascular Surgery | |

A range of services are provided by other Trusts on the EHT site. These include ophthalmology (Moorfields) and Renal Dialysis (Imperial)).

## b) Ealing and Harrow Community Services

### Ealing

**Adult Nursing Services**
District Nursing
Community Matrons
Specialist Nursing including:
- TB
- Diabetes
- Tissue Viability
- Continence
- Heart Failure

Primary Care Access Centre

### Harrow

**Adult Nursing Services**
District Nursing
Community Matrons
Specialist Nursing including:
- Diabetes
- Tissue Viability
- Continence
- Coronary Heart Disease
- HIV
- Intravenous Therapies

Community Assessment Unit
Urgent Care Centre
Continuing Care Team

**Intermediate Care & Rehabilitation**

ARISE - Rehab intermediate care at home

Rehabilitation inpatients at Claypoonds
Rosemary & Jasmin wards

Intermediate Care inpatients admissions avoidance at Clayponds Magnolia ward

Ealing Day Treatment Centre
– walk-in rehab centre

ENABLE – Neurological rehab for progressive disease

Adult Speech & Language Therapy (EHT & community)

**Intermediate Care & Rehabilitation**

HART – Harrow Assessment and Rehabilitation Team

Intermediate care inpatients - Denham Unit

Continuing care – Denham Unit

Physical Disability Support Team

Falls

MS Nurse

**Specialist Services**

Podiatry (EHT & community)

Adult audiology (EHT)

Dietetics & Nutrition (EHT & community)

Musculo-skeletal (MSK) (EHT & community)

Community Dental Service (also provided to Hounslow)

Specialist Palliative Care hospice and community team (also provided to Hounslow)

Learning Disabilities Service

Sexual & Reproductive Health
including chlamydia screening

Primary Care Mental Health & Wellbeing including:
- Primary Care Counselling
- Psychogical Therapies
- Smoking Cessation

**Specialist Services**

Podiatry

Community Dental Service

Specialist Palliative Care community team

Learning Disabilities Service

Contraceptive & Reproductive Health

**Children's Services**

Health Visiting

School Nursing

Child Health Information

Paediatric & Maternity Liaison HV Service

Family Nurse Partnership Project

Haemoglobinopathy

ESCAN – Ealing Services for Children with Additional Needs, including:
- Paediatric Occupational Therapy
- Paediatric Physiotherapy
- Paediatric Speech & Language
- Paediatric Audiology
- Special Schools Nursing

Sure Start

**Children's Services**

Health Visiting

School Nursing

Child Health Records

For NHS Harrow there are some staff currently managed within Ealing and Harrow Community Services who we not expected to transfer, but will stay with NHS Harrow. These are the staff in the NHS Funded Nursing Team (continuing care), the Child Health Records team and the Designated Nurse in the safeguarding team.

## ATTACHMENT 4

# Risk Assessment

### Table A - Top Risks to Establishing the Integrated Care Organisation

| Risk | Consequence | Mitigation |
|---|---|---|
| Three Boards do not agree to proceed on 26 November. | • Delays to<br>o Consultation on Staff Transfer<br>o Referral to Co-operation and Competition Panel<br>o Decision being made before General Election is called.<br>• Causes Go-live date to be delayed.<br>• Damage to:<br>o Staff engagement<br>o Credibility of changes | • Principle supported by all three boards previously.<br>• Detailed Options Appraisal prepared for NHS Harrow and NHS Ealing by EHCS.<br>• Informal sessions held to consider issues.<br>• Detailed Business Case prepared for 3 Boards. |
| Co-operation and Competition Panel recommends disallowing the "merger", or does not reach a decision by 1 April. | • Prevents creation of ICO altogether.<br>or<br>• Delay to creation of ICO beyond 1 April. | • Referral already made. Main documents sent, with Business Case.<br>• Analysis of the effects on competition of alternative scenarios has been prepared for CCP.<br>• Close co-operation with CCP to continue, including rapid responses to requests for further information.<br>• Multiple competitors exist in London. |
| Due Diligence process reveals larger financial challenges than currently understood. Legal due diligence – is it within the vires of EHT and the PCTs to be able to establish an ICO | • Boards pull back from creation of ICO.<br>• NHS London does not confirm its assurance of the transition.<br>• Causes Go-live date to be delayed<br>• or Cancellation.<br>• Legal - potential challenge on having acted ultra vires | • All three current statutory Boards are currently rated Green on Governance.<br>• EHCS has just been judged to be "Business Ready" by NHS London.<br>• Due diligence to be undertaken professionally.<br>• Boards to be fully briefed on outcome of Due Diligence.<br>• Legal advice taken on changes required to Establishment Order and period of consultation. |
| Consultation and notice on Staff Transfers is not completed in time for 1 April 2010. | • Causes Go-live date to be delayed<br>• Or staff have to be seconded before transfer is completed. | • Tight project management of HR Workstream.<br>• Option of secondment until transfers takes place is available, though undesirable. |
| Senior leaders are distracted from programme leadership, by difficult contracting round. | • Loss of senior oversight of Programme to create ICO | • Senior manager recruited as dedicated Programme Director, supported by Programme Manager tracking progress of Workstream plans.<br>• Regular Project Board meetings review progress.<br>• Chief Executives' commitment to deliver the change, as a means to delivering improved services. |
| Staff are not effectively engaged in the process of creating the new organisation. | • Impetus to transform services is lost on creation of ICO. | • Comprehensive Communications and Stakeholder Engagement Strategy in place and resourced. |
| Early General Election | • Delay to creation of ICO beyond | • Recommendation to three Boards is for a |

| | | |
|---|---|---|
| prevents major decisions by statutory bodies (ie Creation of ICO) being taken during pre-Election period, or statutory procedures (ie Establishment Order change). | 1 April.<br>• Delay to change in Establishment Order | clear decision on 26 November, with a confirmation decision later.<br>• Establishment Order change to be requested straight after 26 November. |
| New conclusions on the implications of Healthcare for London are reached by NW Sector or NHS London. | • Delay to creation of ICO beyond 1 April due to uncertainty.<br>or<br>• Prevents creation of ICO altogether. | • Sector have already indicated support for the ICO as strategic direction which fits their analysis.<br>• Continued close working with NHS London and Sector. |
| Overview & Scrutiny Committees (Harrow and Ealing) recommend full public consultation | • Causes new decision date late March.<br>• Delays Staff consultation.<br>• Delays creation of ICO beyond 1 April. | • No service changes are proposed – this is an organisational change.<br>• Assurances given about public consultation on major service changes in future.<br>• Regular dialogue with OSCs in Harrow and Ealing. |
| 5-year Financial Modelling does not meet NHS London requirements. | • NHS London requests a revision of model.<br>Or<br>• NHS London requests a postponement or re-assessment. | • Detailed model in place.<br>• NHS London assumptions used in model.<br>• Detailed review of further iteration of model planned for January.<br>• Regular liaison with NHS London. |
| Support services transferring are not ready to provide a robust service from 1 April. (eg Payroll, Finance, IT) | • Operational difficulties in first months of ICO | • Workstreams building project plans, with progress monitored by programme manager.<br>• Short-term work-arounds would be found. |
| Risk of maintaining the status quo | • We will not have an organisation(s) fit for purpose to deliver care in an increasing sub-specialisation environment or be able to deliver effective care closer to home. | • Options appraisal undertaken that illustrate that status quo not an option and the ICVO best organisational model to address the drivers for change.<br>• Business case developed to illustrate that the ICO is the best organisational model and that status quo not an option. |

## <u>Table B</u> - Top Risks to Ongoing Success of the Integrated Care Organisation

| **Risk** | **Consequence** | **Mitigation** |
|---|---|---|
| Senior Leadership of the ICO not turning the vision into reality. | • Lost opportunities and purpose of ICO.<br>• Organisation fails to deliver service and financial changes.<br>• Leading to ICO being acquired.. | • Development of vision into a clear plan.<br>• ICO Board focuses on delivery of vision as well as short-term performance.<br>• Plan to develop Executive team, and Clinical Board members. |
| New management and leadership arrangements do not have the capacity or capability to deliver service transformation required. | • Lost opportunities and purpose of ICO.<br>• Organisation fails to deliver service and financial changes.<br>• Leading to ICO being acquired. | • ICO Board focuses on governance arrangements.<br>• Plan to develop Executive team, and Clinical Board members. |
| Cultural differences between the three former organisations are not addressed, and no new culture established. | • Transformation of services severely restricted.<br>• Time and effort wasted. | • Development of OD plan for ICO.<br>• Leadership by top team. |

| | | |
|---|---|---|
| The ICO does not focus sufficiently on clinical care, so that quality of care declines. | • Poorer service to patients<br>• Loss of CQC registration<br>• Commissioners move contracts elsewhere | • Governance arrangements<br>• CQC self declarations<br>• Commissioner monitoring |
| Financial environment means the scale of savings required makes the organisation unviable. | • Poorer service to patients.<br>• Organisation fails and is acquired. | • Develop a robust savings plan.<br>• Agree realistic funding and service priorities, between commissioners and provider. |
| Financial savings required are responded to by making such large savings in community services as to make the benefits of integration undeliverable. | • Unable to deliver transformation.<br>• Organisation becomes uncompetitive and then unviable. | • ICO Board monitors balance of savings.<br>• Major savings in community services agreed with commissioners. |
| Incentives for care outside hospital, and new ways of commissioning services, are not agreed for years 1 and 2. | • Loss of incentive to drive care at home.<br>• Financial instability for ICO and commissioners | • Plan to agree outline framework for year 1, and gradual move away from tariff in years 2-4.<br>• ICO and NHS Ealing Boards monitor progress. |
| Acute services move from Ealing Hospital site from Year 2 onwards without sufficient replacement sources of income to service the costs of the EH site. | • Financial burden of EH site makes ICO unviable. | • Any service moves are planned and controlled.<br>• New users of space and sources of income are planned over 5 years. |
| Community nursing recruitment and retention threatens continuation of these core services. | • Unable to deliver core community services.<br>• Opportunities from Integration are lost.<br>• Organisation becomes uncompetitive and then unviable. | • Recruitment and Retention plan to be incorporated in Workforce Plan.<br>• Monitoring R&R data by governance structure. |
| Some acute services become unviable in advance of decisions being consulted upon and planned. | • Unplanned loss of services<br>• Loss of reputation with partners and public<br>• Financial pressures | • Review of acute services during 2010, to assess risks and plan for future.<br>• Close working with commissioners on future strategy for acute services.<br>• Agreement of NHS Ealing to avoid destabilising the ICO in its first year. |
| Competitors use their stability and scale to capture core ICO services, before gains of ICO are delivered. | • Loss of income<br>• Potential loss of ability to transform services. | • Close working with commissioners to reduce risk.<br>• Assessment of risks to be included in Annual Plan<br>• Establish Business Development function early in life of ICO. |
| Commissioners move to tender core ICO services before the ICO is ready. | • Loss of income<br>• Potential loss of ability to transform services. | • Close working with commissioners to reduce risk.<br>• Assessment of risks to be included in Annual Plan<br>• Establish Business Development function early in life of ICO. |

# ATTACHMENT 5

# Effects on Competition of Alternative Scenarios

## 1. Introduction

This paper summarises the effects on competition in different areas of Ealing and Harrow, and its surrounding areas, if a range of scenarios were to occur in the future. It provides an outline of what might happen , if the Integrated Care Organisation were not to come about.

The analysis looks ahead around two years, to a point where the community services have had to separate completely from their commissioning PCTs, and where Ealing Hospital NHS Trust has had to become part of one or other Foundation Trust – for the reasons described in the Business Case.

The scenarios are summarised in a chart at the end, whose shading shows the degree of competition that is lost in each scenario.

## 2. Key Factors determining the scenarios

**Long term Options for Harrow Community Services**
The conclusion of NHS Harrow has been that the community services of NHS Harrow would not be viable on their own. This is due to their relatively small size, turnover being £17million. Therefore, every scenario below presumes that there has already been the loss of one community provider (so this is not included in the scoring).

**Long term Viable Options for Ealing and Harrow Community Services**
It has also been concluded that EHCS is not large enough to become a Foundation Trust on its own, having a turnover of around £65million, compared to a threshold of around £100million. Therefore, EHCS would need to combine with another provider if it remained an NHS organisation. An alternative is to become a Social Enterprise. This generates five potential outcomes for the Community services:

- Creating an **Integrated Care Organisation** with Ealing Hospital.
- Standing **Alone** (either as a Social Enterprise, or as part of Another Trust not directly involved in local community or local acute services – eg a mental health provider, or a more distant acute trust beyond the local area).
- Joining **Another Community Provider** (the most likely examples being Central London Community Health to the East, Hillingdon to the West, Brent to the North and East, and Hounslow/Richmond to the South)
- Joining **North West London Hospitals NHS Trust** (the major acute provider with Northwick Park Hospital serving Harrow and Brent, and Central Middlesex Hospital serving Brent and parts of Eastern Ealing.)
- Joining **Imperial College Healthcare NHS Trust** (the major acute and academic centre to the east of Ealing, which serves the eastern part of Ealing for acute services, and also specialist services. This Trust includes the Hammersmith Hospital, Charing Cross Hospital, St Mary's Hospital, Queen Charlotte's and Chelsea Hospital and the Western Eye Hospital).

**Long term Viable Options for Acute Services at Ealing Hospital**
Ealing Hospital will not be able to proceed to become a Foundation Trust on its own, because of its relatively small size, and because of uncertainties about the future of some of its acute services. Therefore four main alternatives are considered:

- Joining **Imperial College Healthcare NHS Trust**
- Creating an **Integrated Care Organisation** with community services.
- Joining **North West London Hospitals NHS Trust**
- Joining **Another Acute provider** (for example Hillingdon Hospitals)

## 3. Comparing the scenarios

The five community options are set alongside the four acute options to make a total of 13 scenarios in the table on the next page. The consequence for competition is shown for each scenario across four geographical areas.

It should be noted that this analysis assumes all the other providers remain as they are. It is more likely that some will combine over the coming years. This makes it all the more valuable to retain competition amongst local providers.

For the purposes of this analysis, losing one whole provider from the competitive market is given a value of -1. The later three changes are given a value of 0.5, as they are about the quality of competitors available, and because currently there is very little if any effective competition between acute and community providers in Ealing and Harrow. *Note again the point made above that all the scenarios presume it is inevitable that competition would already have been reduced by one community provider (as Harrow would not survive alone), and this is therefore not shown in the scoring.*

| - Loss of 1 acute provider | - 1 |
|---|---|
| - Loss of 1 community provider | -1 |
| - Loss of competition between community and acute providers to the same population | -0.5 |
| + Gain a stronger provider of community services, more able to compete through being linked to an acute provider. | +0.5 |
| - The creation of a very large provider dominating the local health system, and driving out competition. | -0.5 |

These scores are totalled and shown visually by shading the final table on the next page: the darker the shading, the larger the loss of competition.

| | + 0.5 |
|---|---|
| | -0.5 |
| | -1 |
| | -1.5 |
| | -2 |

| Potential merger partners | | Effects on competition in different areas | | | |
|---|---|---|---|---|---|
| **Community** | **Acute** | **Harrow**<br><br>Current acute = NWLHT | **Main Ealing**<br><br>Current acute = EHT | **Eastern Ealing**<br><br>Current acute = Imperial | **Surrounding PCTs**<br><br>Various acute |
| **Alone**<br>(Social Enterprise or Another trust eg Mental Health) | **Imperial** | -1 acute | -1 acute | -1 acute | -1 acute |
| **Another Community Provider**<br>(CLCH, Hillingdon, Brent) | **Imperial** | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community |
| **NWLHT** | **Imperial** | -1 acute<br>- community/acute | -1 acute<br>+ stronger community | -1 acute<br>+stronger community | -1 acute<br>+stronger community |
| **Imperial Healthcare** | **Imperial** | -1 acute<br>+stronger community<br>- v large provider | -1 acute<br>- community/acute<br>- v large provider | -1 acute<br>- community/acute<br>- v large provider | -1 acute<br>+stronger community<br>- v large provider |
| **Integrated Care Organisation** | **Integrated Care Organisation** | No reduction<br>+ stronger community | - community/acute | No reduction<br>+ stronger community | No reduction<br>+ stronger community |
| **Alone**<br>(Social Enterprise or Another trust eg Mental Health) | **NWLHT** | -1 acute | -1 acute | -1 acute | -1 acute |
| **Another Community Provider**<br>(CLCH, Hillingdon, Brent) | **NWLHT** | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community |
| **NWLHT** | **NWLHT** | -1 acute<br>-community/acute<br>- v large provider | -1 acute<br>-community/acute<br>- v large provider | -1 acute<br>+ stronger community<br>- v large provider | -1 acute<br>+stronger community<br>- v large provider |
| **Imperial Healthcare** | **NWLHT** | -1 acute<br>-1 community<br>+ stronger community | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community<br>+stronger community |
| **Alone**<br>(Social Enterprise or Another trust eg Mental Health) | **Another acute**<br>eg Hillingdon | -1 acute | -1 acute | -1 acute | -1 acute |
| **Another Community Provider**<br>(CLCH, Hillingdon, Brent) | **Another acute**<br>eg Hillingdon | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community | -1 acute<br>-1 community |
| **NWLHT** | **Another acute**<br>eg Hillingdon | -1 acute<br>-community/acute | -1 acute<br>+stronger community | -1 acute<br>+stronger community | -1 acute<br>+stronger community |
| **Imperial Healthcare** | **Another acute**<br>eg Hillingdon | -1 acute<br>+ stronger community | -1 acute<br>+ stronger community | -1 acute<br>+ stronger community | -1 acute<br>+stronger community |

## 4. Conclusions

This analysis shows clearly that:

- the Integrated Care Organisation provides the scenario with the least reduction in competition.

- all the other scenarios would result in a greater reduction in competition, some of them by two whole providers.

- the Integrated Care Organisation would actually increase competition in Harrow, and eastern Ealing, and in areas surrounding Ealing and Harrow, by creating a stronger community competitor.

## ATTACHMENT 6

# ICO Implementation Plan

**Programme Structure**

The programme of work to implement the ICO is being led by the Project Board, which consists of the Chairs and Chief Executives/Managing Director of the three statutory organisations and EHCS.

The Programme Director, Jonathan Carmichael, moved from his director role in EHCS in mid October, and is shortly to be joined by a Programme Manager Yashoda Patel part-time. Seven workstreams are being led by senior managers from the organisations involved:

| Workstream | Lead |
|---|---|
| Clinical Operations | Julie Lowe, Chief Executive, EHT |
| Commissioning Framework | Jon Ota, Managing Director EHCS<br>& Director NHS Harrow |
| Communications | Jonathan Carmichael, Programme Director<br>& ex-Director EHCS |
| Corporate Governance | David James, Board Secretary, EHT |
| Finance | David Pratt, Finance Director EHT<br>& David Slegg, Finance Director NHS Ealing |
| Human Resources | Paul Stanton, Director of HR, EHT |
| IT | Kevin Connolly, Director of IT, EHT |

An outline of the Programme Plan is given below, and key elements of this are shown in the Gantt charts which follow. This version of the charts focuses on displaying the tasks which are most important to achieving the organisational change in time for April 1 2010, and their dependencies.

In December, provided agreement to proceed is given on 26th November, a further phase of planning will take place. This will provide more detail on the periods January to March, and April to June, and add a number of elements, such as Information, Organisational Development and Estates.

The Communications and Stakeholder Engagement Strategy is included separately at Attachment 7.

A theme of the planning for this programme is the very tight timescales. To implement the new organisation in four months will require considerable investment of time from senior managers across the four organisations – particularly as no project managers have been engaged to support the individual workstreams. Consequently, only those tasks which are essential to be delivered by 1 April are being prioritised. This inevitably means that in April-June there will continue to be tasks to be completed which would ideally have been done earlier.

**Highlighted elements of the programme**

**Communications and Stakeholder Engagement Strategy**

A detailed strategy and plan has been prepared by Steve Spray, Head of Communications for EHCS, in conjunction with communications colleagues in each organisation. This is reproduced in Attachment 7. The major focus initially will be internally with the staff to be transferred, and with key stakeholders externally. This broadens to include a wider group of staff and stakeholders, including the public, as the plan progresses.

**Co-operation and Competition Panel**

This national body will need to make a recommendation to NHS London on the effects of the change on the competitive environment. Whilst this is legally a transfer, the Co-operation and Competition Panel (CCP) will treat this as a "merger", as they do for any joining together of NHS organisations. The CCP's recommendation, if agreed with by NHS London, would have the power to stop the creation of the ICO, so it has considerable importance.

The ICO has already been referred to the CCP by the participating organisations and discussed with CCP representatives. A large volume of documents will accompany this Business Case on 20 November, so that the CCP can begin its preparatory work. Once the CCP is satisfied that it has sufficient information, it will formally accept the case. The CCP then guarantees to make a response within 8 weeks. This is currently expected to be in the middle of February. However, should it require further consideration, there is potentially a second phase of up to 16 weeks. A second phase potentially take the process past 1 April. However, none of the completed cases have moved into a second phase to date.

The local organisations' leaders are confident that a second phase should not be necessary, as a strong case can me made that competition will not be unduly restricted by creating the ICO. Indeed, an argument can be made that the ICO will be in a very much better position to compete with other organisations, both within Harrow and Ealing, and in surrounding area. This is due to its provision of both acute and community services, and the range of clinical staff available across the new organisation.

An analysis of the competitive environment has been prepared, comparing the effects of creating the ICO with a range of likely alternative scenarios. This is included as Attachment 5. This makes clear that each of the three elements coming together to create the ICO would otherwise need to join some other organisation. All of these alternative scenarios are shown to reduce competition by more than the creation of the ICO.

The CCP have noted that for their purposes they will be examining the change as a three-way merger, and this will be the first case of its kind for the CCP to review.

**Overview and Scrutiny Committees**

Further important stakeholders are the Overview and Scrutiny Committees of the London Boroughs of Ealing and Harrow. The respective PCTs have been in dialogue with the OSCs for some time about the prospect of the creation of the ICO. Each body will consider this at their meetings in early December.

Overview and Scrutiny Committees will take a view on whether changes in NHS services require a full public consultation. The creation of the ICO does not of itself change the services that are provided to the local populations. Rather, it creates the potential for changes in the future. Therefore the NHS organisations do not consider that the change requires public consultation, or indeed meets the criteria for public consultation. This would take place when or if major changes are proposed, at a later date. However, the programme needs to take account of the risk that the OSCs may take a different view.

**Due Diligence**

A process of due diligence will be undertaken following the decision to create the ICO. This will allow all the parties, in particular the Board of EHT as the receiving organisation, to have sufficient assurance about the transfer process. Legal advice on workforce consultation and changes to the establishment order can be found at Attachment 8.

A proposal on the form of this due diligence will be agreed after this paper goes to press, and will be communicated at the joint Board session.

**Financial & Service Planning**

The financial planning for the ICO is addressed in Section 7. This will continue to be refined during December, and will be reviewed by Boards and NHS London ahead of the transfer taking place.

It is expected that planning for 2010/11 and beyond will be undertaken jointly, in preparation for the ICO.

**New Operating Name**

Finding, consulting on and choosing the new operating name for the ICO is part of the Communications Workstream. The aim is to bring a recommendation by February at the latest, to allow time to operationalise it.

The intention is for the statutory body to continue to be called Ealing Hospital NHS Trust, but using a different operating name. This is not uncommon for companies and charities, and there are a number of examples within the NHS. Indeed, Ealing and Harrow Community Services operates in this way currently, with its own NHS branding. The ICO will ensure that local services and venues will be given clear sub-brands which the public can relate to (for example Ealing Hospital, Harrow District Nursing Service etc), which will be developed as part of the Strategy.

It is anticipated that the statutory body may seek to change its name to become the same as the operating name, late in 2010/11.

**Change Establishment Order**

By contrast, one change that is essential is to widen the purposes (or "objects") of Ealing Hospital NHS Trust, to allow it to provide community services from other sites. This change is timetabled to take place well within the required period, having already been agreed by the Board of Ealing Hospital NHS Trust.

**Transfer Document**

A legal transfer document will be prepared for agreement between the three statutory bodies. This will be simpler than some transfers, as there are no estate assets transferring.

**Staff Transfer**

The Human Resources Workstream, made up of the directors responsible for HR and staff side representatives, are preparing a consultation on the transfer of staff from Harrow PCT and Ealing PCT to EHT.

The Workstream group has yet to conclude the exact timing of the consultation before this paper goes to press, ahead of its meeting on 23 November. However, it is likely to commence very shortly after the Boards meet to decide on the ICO, in order to make available all the information and support systems as soon as possible, and avoid a gap which would be filled by rumours and presumptions. An update will be given at the joint Board session.

**Finance and IT**

A series of background changes will be needed to effect the change, and plans are being prepared.

On the finance side, a key deliverable before 1 April is the payroll arrangements from April. This payroll work is reporting jointly to the Finance and Human Resources workstream.

On IT, the key deliverable before 1 April is to have all staff working behind the same firewall for security purposes. Moving to common email systems would also be highly desirable, although contingency arrangements may be needed for a short period.

**Service Changes**

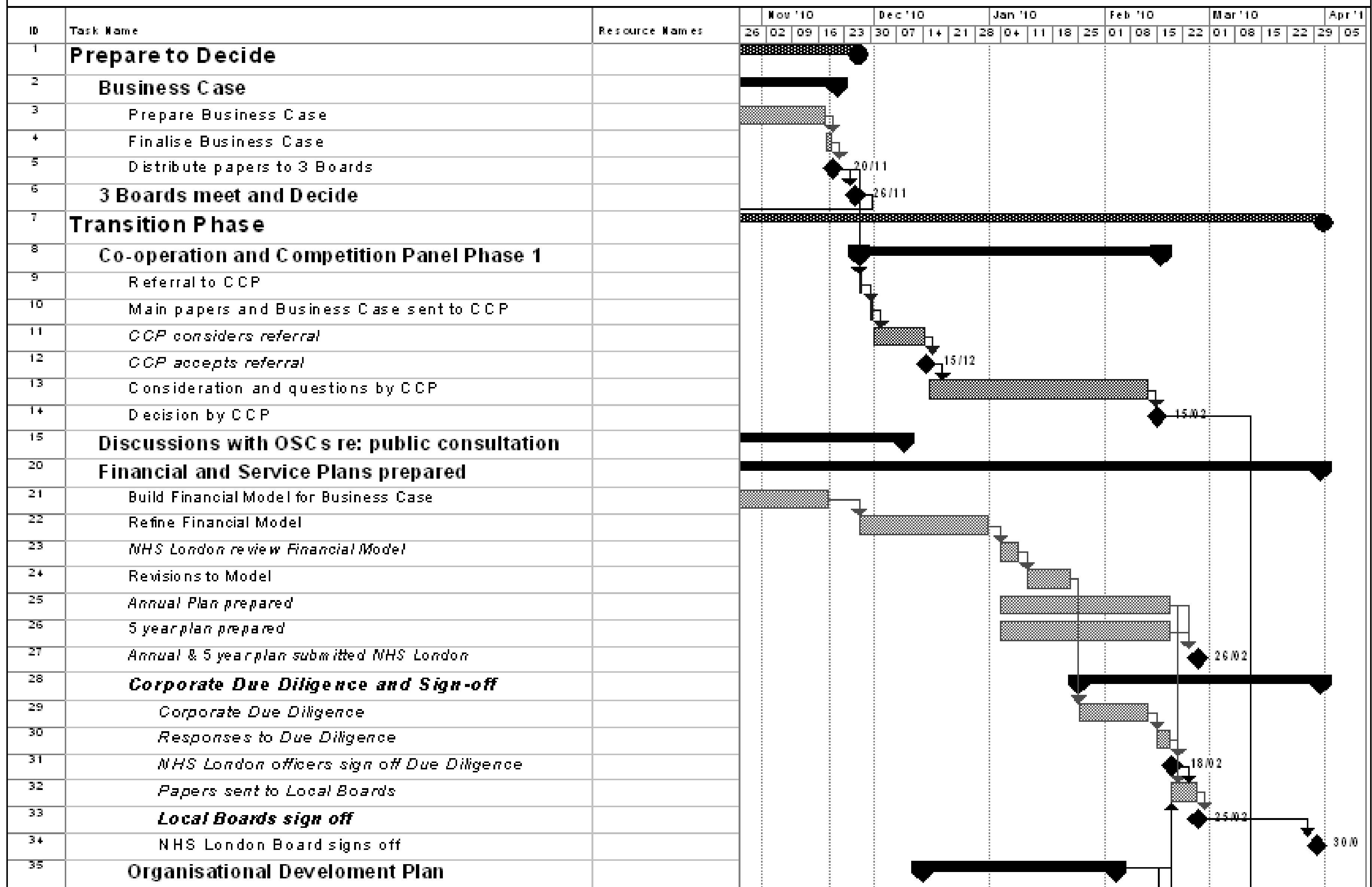
A review of acute services will be undertaken from January 2010, running into the summer of 2010. It is anticipated that should major changes be planned, there would be a period of public consultation potentially in the autumn or winter period of 2010, possibly in conjunction with other parts of NW London.

In parallel, there will be a review of which services should become integrated in the first year of the ICO, either between community and acute, or across community services in Ealing and Harrow.

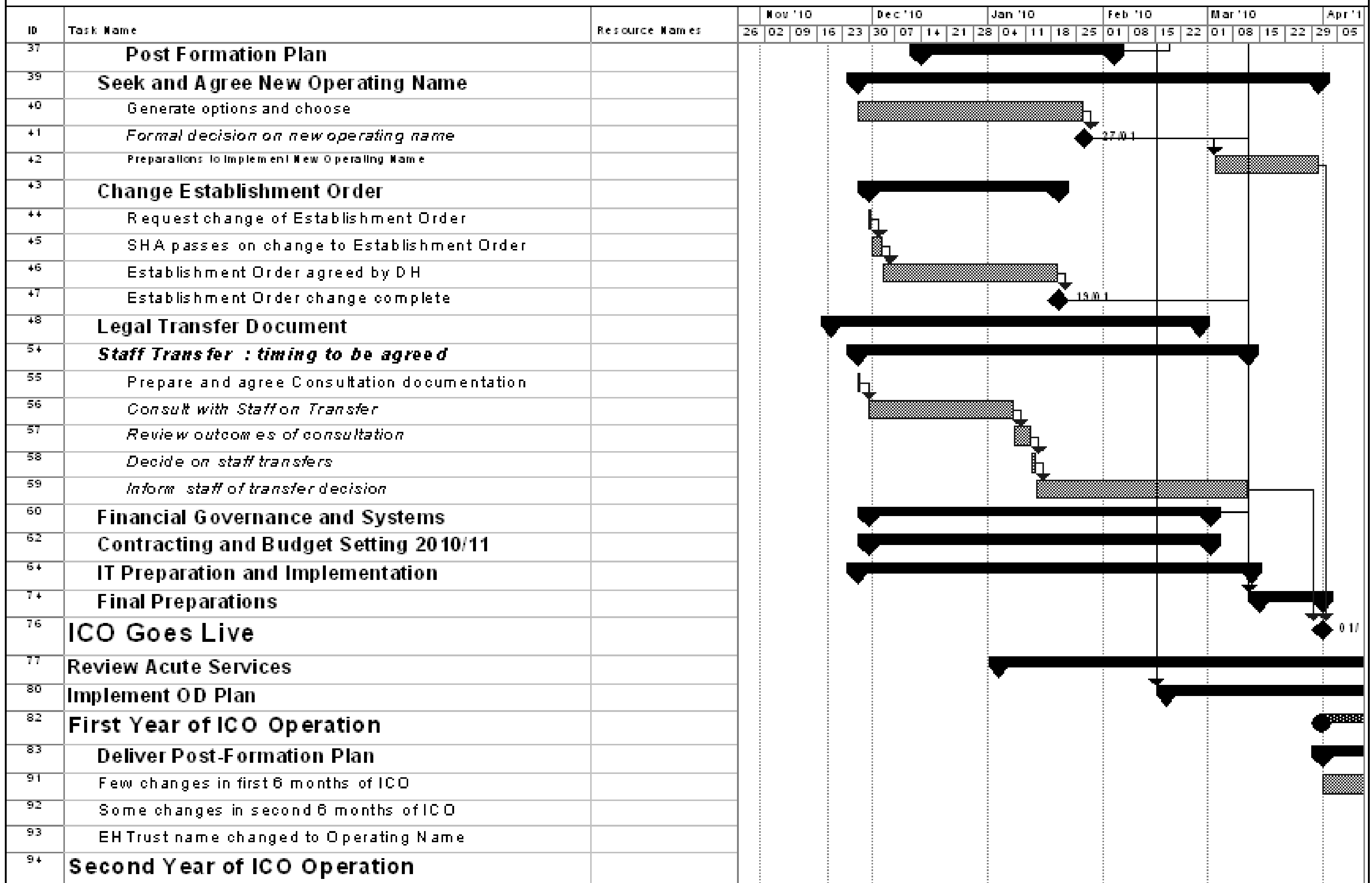
Therefore, it is expected that the first year of operation of the ICO will see some changes to services and structures. However, the larger changes are more likely to occur in the second year, 2011/12.

**Conclusion on Implementation**

The implementation phase will be to a tight timescale, and entails intensive actions across a wide range of the organisations' functions. It is inevitable that some tasks will have to be undertaken after the "Go Live" date of 1 April 2010. However, at this point in the programme, there is time to complete the essential items, with careful planning.



Creating an Integrated Care Organisation for Ealing and Harrow
ID
Task Name
Resource Names
Nov '10
Dec '10
Jan '10
Feb '10
Mar '10
Apr '1
26 02 09 16 23 30 07 14 21 28 04 11 18 25 01 08 15 22 01 08 15 22 29 05
1 Prepare to Decide
2 Business Case
3 Prepare Business Case
4 Finalise Business Case
5 Distribute papers to 3 Boards
20/11
6 3 Boards meet and Decide
26/11
7 Transition Phase
8 Co-operation and Competition Panel Phase 1
9 Referral to CCP
10 Main papers and Business Case sent to CCP
11 CCP considers referral
12 CCP accepts referral
15/12
13 Consideration and questions by CCP
14 Decision by CCP
15/02
15 Discussions with OSCs re: public consultation
20 Financial and Service Plans prepared
21 Build Financial Model for Business Case
22 Refine Financial Model
23 NHS London review Financial Model
24 Revisions to Model
25 Annual Plan prepared
26 5 year plan prepared
27 Annual & 5 year plan submitted NHS London
26/02
28 Corporate Due Diligence and Sign-off
29 Corporate Due Diligence
30 Responses to Due Diligence
31 NHS London officers sign off Due Diligence
18/02
32 Papers sent to Local Boards
33 Local Boards sign off
25/02
34 NHS London Board signs off
30/0
35 Organisational Develoment Plan
Page 1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Nov '10
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Mar '10
Apr '1
26 02 09 16 23 30 07 14 21 28 04 11 18 25 01 08 15 22 01 08 15 22 29 05
37 Post Formation Plan
39 Seek and Agree New Operating Name
40 Generate options and choose
41 Formal decision on new operating name
42 Preparations to implement New Operating Name
43 Change Establishment Order
44 Request change of Establishment Order
45 SHA passes on change to Establishment Order
46 Establishment Order agreed by DH
47 Establishment Order change complete
48 Legal Transfer Document
54 Staff Transfer : timing to be agreed
55 Prepare and agree Consultation documentation
56 Consult with Staff on Transfer
57 Review outcomes of consultation
58 Decide on staff transfers
59 Inform staff of transfer decision
60 Financial Governance and Systems
62 Contracting and Budget Setting 2010/11
64 IT Preparation and Implementation
74 Final Preparations
76 ICO Goes Live
77 Review Acute Services
80 Implement OD Plan
82 First Year of ICO Operation
83 Deliver Post-Formation Plan
91 Few changes in first 6 months of ICO
92 Some changes in second 6 months of ICO
93 EH Trust name changed to Operating Name
94 Second Year of ICO Operation
27/01
19/01
01/
Page 2

**ATTACHMENT 7**

**Communications and Stakeholder Engagement Strategy**

# Integrated Care Organisation

## Change Communications Plan

## Content


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| 3 | Communications Objectives | 8 |
| 4 | Communications Challenges | 9 |
| 5 | Mission, Vision, Values and Promises | 11 |
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| 7 | Name | 13 |
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| 9 | Stakeholders | 15 |
| 10 | Media | 21 |
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# 1. Background

## Pan-London Perspective

Lord Darzi's *Framework for Action* sets out the findings from his review of healthcare across London. This independent study details how London's healthcare provision needs to change over the coming years to meet the needs and expectations of the people of London. Clinicians from across London were involved in the review, as were the people of the Capital, who said that they want to be treated closer to home, promptly, at locations and times that are convenient to them.

The recommendations of Lord Darzi's report call for provision tailored to individual needs. Where possible, routine healthcare services should be delivered locally, with some specialist acute services only being available at central locations. The report emphasises the benefits of partnership working, both within the NHS and between the NHS and other organisations, such as the voluntary and private sectors. It states that within the NHS the areas of community and hospital healthcare should be better connected, bringing together practitioners from different disciplines. A joint proactive approach to healthcare will help people stay mentally and physically healthy, and a reduction of health inequalities will be achieved by increasing access to high quality healthcare and the information that will allow patients to make informed choices about their individual health needs.

The five principles of this system of healthcare are summed up in the Darzi review as follows:

- **Services should be focused on individual needs and choices.**
- **Services should be localised where possible and regionalised where that improves the quality of care.**
- **There should be joined-up care and partnership working, maximising the contribution of the entire workforce.**
- **Prevention is better than cure.**
- **There must be a focus on reducing differences in health and healthcare.**

## Local Perspective

The Boards of NHS Ealing, NHS Harrow and Ealing Hospital NHS Trust have set out their vision for local healthcare in Ealing and Harrow, which is consistent with Lord Darzi's *Framework for Action*.

In-line with the national agenda for Primary Care Trusts, NHS Ealing and NHS Harrow have already made significant progress in separating their responsibilities for commissioning and services delivery. A joint, autonomous provider organisation, Ealing and Harrow Community Services (EHCS) was formed in April 2009. This organisation was awarded 'Business Ready' status by NHS London in October 2009. Currently, EHCS is hosted by NHS Ealing and NHS Harrow and provides NHS community healthcare services primarily in the London Boroughs of Ealing and Harrow. Authority to manage the services provided by the organisation has been delegated to the EHCS Board from the Boards of NHS Ealing and NHS Harrow. EHCS is not considered to be large enough to be viable on its own, and therefore needs to enlarge its portfolio of services.

Ealing Hospital NHS Trust (EHT) is the smallest acute trust in London and has been characterised as unable to achieve Foundation Trust (FT) status in the current London environment. The policy directive that acute care should be delivered from FT's means that EHT cannot continue in its present form. It is not planned that EHT

will become one of the major acute trusts for this part of London, and it has described itself as a ‘local’ hospital within the Darzi definitions.

The vision that is currently being developed is to create a new type of NHS organisation, delivering local community healthcare by integrating the majority of the services that currently sit within EHCS and EHT. The new Integrated Care Organisation (ICO) will be large enough to remain viable, while providing healthcare in concert with the five principles set out by Lord Darzi.

## 2. Benefits of Creating an ICO for Ealing and Harrow

For the people who live in our community and work in our services there are major benefits in creating an ICO. By improving the system by which healthcare is delivered, we will ensure that the patient experience and staff satisfaction are improved.

We have grouped the six key benefits that will be delivered into three areas:

- **Benefits for Patients:**
  - Enabling new models of service provision and patient care.

- **Benefits for Staff:**
  - Greater support for clinical practice and enabling clinical leadership.

- **Benefits for the local Healthcare System:**
  - Incentives which Promote Care within the Community.
  - Better use of resources.
  - Achieving a viable organisation.
  - Encouraging providers and commissioners to work together with incentives that promote care out of hospital.

**Benefits for Patients:**

- **Enabling new models of service provision and patient care**
  There are many opportunities to improve patient care by removing boundaries between acute and community services, in line with the policy of Transforming Community Services. Examples include:

  - **Greater continuity of care** – as care is organised across hospital and community settings, involving the same professionals in a variety of settings, or working together as an extended team.
  - **Fewer barriers for patients and faster access** – as care is re-designed so that patients flow more easily through the system, removing artificial barriers, speeding up patients through each stage in the process, instead of patients having to start again when referred elsewhere.
  - **More focus on long-term conditions** – as the organisation focuses on the whole of the individual's needs over a longer period, instead of the occasion when the patient presents to one service.
  - **Care based on the best evidence** – as models of care are designed on evidence, instead of being based on organisational structures.
  - **Fewer visits to hospital** – as more one-stop clinics are developed, with a range of professionals from different disciplines all working together within one co-ordinated system.

- **Fewer duplicated assessments and tests** – as information is able to flow better between professionals, through using the same record systems, and greater use of shared guidelines.

**Benefits for Staff:**

- **Greater support for clinical practice and enabling clinical leadership:**
  - **Specialist skills and expertise** can be accessed by teams in different care settings.
  - **Clinical practice developed** with more support across disciplines, and by larger central teams.
  - **Clinical leaders** are more able to develop their services across a wider community, and apply their skills and experience for the benefit of more teams and patients.
  - **Learning and best practice** being brought from one area to another
  - **Senior clinical leaders** being attracted to an organisation with a clear focus on community services and care closer to home.
  - **A broader range of senior clinicians** will be involved in leading service improvements, including nurse consultants, medical consultants, consultant therapists and others, to provide strong leadership and deliver change.
  - **New career pathways and new job roles** will be developed, around delivering integrated care across the acute and community services.

**Benefits for the local Healthcare System:**

- **Incentives which Promote Care within the Community:**
  - Incentives could be agreed which promote care out of hospital, by Commissioners working with a unified organisation, replacing the current pricing structure that encourages multiple visits to hospital and inpatient care.

- **Focusing on local services and on services provided in the community:**
  - **A strong focus on care closer to home and care in the home**, from an organisation dedicated to this, with experienced leaders capable of delivering improvements**.**
  - **Care that is local where possible and central where necessary**, following the strategy of Healthcare for London, promoting.
  - **Stronger links with primary care** for some acute services, by integration with community services.
  - **A locally managed future for some acute services** is more secure, rather than becoming part of a much larger acute organization**.**

- **Better use of resources:**

  - **Overhead costs** of creating a whole extra community services organisation are avoided - or two extra organisations (one for Harrow and one for Ealing).
  - **Support service departments** can be shared, so reducing costly duplication.
  - **Capital funds** for community services would be more available, which were very limited while in PCTs.

- **Achieving a viable organization:**

  - **An organization large enough to stand on its own**, and progress to Foundation status would be created. This is the only long-term future for NHS acute hospitals, and the preferred long-term future for community services.
  - **The separation of PCTs' provider and commissioner functions** would take place, so that each can focus on their own core purpose.
  - **Swift and certain separation** would take place, instead of a two or three-year delay and uncertainty whilst trying to create a brand new Community Foundation Trust.
  - **A strong business development function** would be justified by a larger organization, capable of competing in a rapidly developing market for health care.
  - **Vulnerability would be reduced** - from the loss of services to other organisations, either through transfers or through competition.

In summary, establishing an ICO will create a single organisation with a single governance structure to allow the benefits described here to be realised more easily and reliably than through collaboration across organizational boundaries.

## 3. Communications Objectives

The objective of this plan is to support the creation of the ICO, by putting in place communications tools and activities that will enable internal and external stakeholders to understand and support the significant organisational change that is being proposed for all organisations involved.

This main objective can be broken down as follows:

1. **Develop stakeholder understanding of the reasons for the change that is taking place.**
2. **Develop stakeholder understanding of the purpose and role of the ICO.**
3. **Build and maintain stakeholder confidence in the plan for creating the ICO.**
4. **Enable stakeholders to shape and become advocates of the ICO.**
5. **Enable patients and the public to understand how the ICO operates and its services can be accessed.**

# 4. Communications Challenges

- **Knowledge Gap;**
- **Mixed Messages;**
- **Negative Political Interest;**
- **Public Attachment to their Local Hospital**;
- **Brand Poverty;**
- **Name; and**
- **Other Challenges.**

### Knowledge Gap
A lack of understanding of the reasons for creating the ICO will prevent stakeholders from playing their part in enabling change. Additionally, any knowledge gap is likely to be filled with inaccurate information (rumour/speculation), which will hinder the change process by creating/fuelling fear or confusion in the minds of stakeholders.

Inaccurate information/different views are likely to be propagated by parties opposed to this change, and will compete for acceptance in the minds of stakeholders.

Stakeholders will need to buy into the argument for creating the new organisation before they can become advocates. They will also need the relevant knowledge and tools to become effective ambassadors.

### Mixed Messages
It is important that messages are clear, consistent, and able to withstand challenge. Unclear or mixed messages will lead to confusion and/or misinterpretation. Messages that cannot withstand challenge, will lead to a lack of confidence and/or mistrust. Internal and external cross-organisational messaging will need to be precisely coordinated - what is said, when, why, to whom and by whom.

### Negative Political Interest
This organisational change will provide the opportunity for special interest/political groups to make capital/gain ground for their agenda by fuelling the concerns among stakeholders by presenting the ICO proposal in a negative light. There is a risk that with the impending local and general election this change may attract a greater level of attention than it would at other times in the political cycle.

### Public Attachment to their Local Hospital
People tend to have a love/hate relationship with their local hospital, while they will happily voice criticism about the service they receive; they also tend to become very defensive if they feel that there is a danger that services may be taken away from them.

### Brand Poverty
Without a clear brand identity, the ICO will find it difficult to effectively communicate messages about its services, the values it holds and the unique nature of its offer. Stakeholders will have difficulty in understanding the quality or characteristics of the services on offer, what the ICO does and can provide.

### Name
A new name will be required for the new organisation. However, staff who work for EHCS have recently taken part in a process to decide on the new name for their organisation. Revisiting the naming of the organisation at this stage with this staff

group will need to be handled delicately, as their confidence in the worth of engaging could be damaged if they feel that the decision into which they input is being overturned after such a short period of time.

### Local and National Elections

We are approaching a pre-poll period in which government departments, council offices and other public bodies should not make politically contentious announcements, or do anything that could be construed as being politically biased.

### Other Challenges

During a workshop attended by the EHT Leadership Team earlier this year, work took place to capture the key communications issues/challenges of the ICO project and how these could begin to be addressed. It is now proposed that these workshops are replicated with the Leadership Teams of NHS Ealing, NHS Harrow and EHCS. This will allow a full range of issues/challenges to be identified by providing perspective from each of the groups involved in creating the ICO. The outputs from each group will be drawn together to identify all foreseeable issues and challenges.

# 5. Mission, Vision, Values and Promise

To build stakeholder understanding and support for the new organisation, we need to develop a mission and vision as well as values and promises that all stakeholders can sign up to. The process of developing the organisation's mission, vision, values and promise in itself presents an opportunity to engage with stakeholders. It is proposed that visioning workshops are now run with the Leadership Teams at NHS Ealing, NHS Harrow and EHCS. A similar workshop has already been held with the EHT Leadership Team. The work from all four workshops will be brought together to identify and agree a vision for the new ICO.

Staff, patient, public and other stakeholders will be engaged in this work through focus groups. This piece of work will also help the new organisation align itself with the NHS Constitution, which highlights the importance of developing a set of values that are determined locally for each NHS organisation, and are developed through discussions with patients, staff and the public.

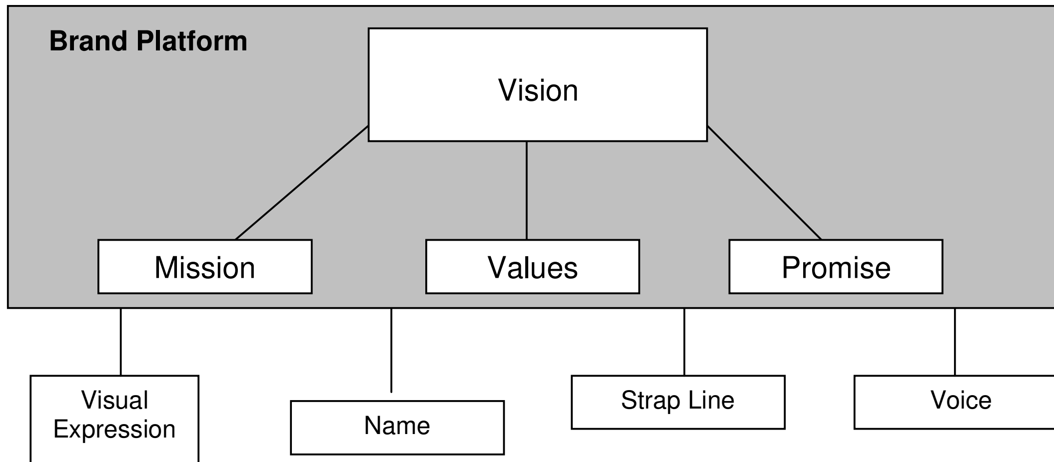
The organisation's vision will be expressed as its aspirations. The organisation's mission will be expressed as the goals/objective, the levers that will enable it to deliver its vision. Its values will be used to guide the way things are done, and the way we act towards each other and our customers. Our promises will tell our stakeholders what we will do for them.

The leaders who attended the individual organisation based meetings will be brought together as a single group to agree the mission, vision, values and promises for the new organisation. Staff, public and patients who take part in the focus group will be offered the opportunity to attend feedback sessions once the mission, vision, values and promises have been agreed.

An activity plan will be developed to communicate the new organisations mission, vision, values and promises to all stakeholders, and will emphasise role that staff, members of the public and patient had in their development. This piece of work will require the support of additional external resources.

# 6. Brand

Once the brand platform consisting of the mission, vision, values and promises has been developed, the visual expression, name, strap line and voice of the new organisation will be developed.




In the short-term, it will be necessary to give the transition project an identity that will enable it to be easily recognised.

A set of style templates will be created to achieve this, which will include:

1. **Project Identifier – identifying mark for use on all materials.**
2. **Document Cover.**
3. **Poster.**

These will then be populated as required by either internal or external resources.

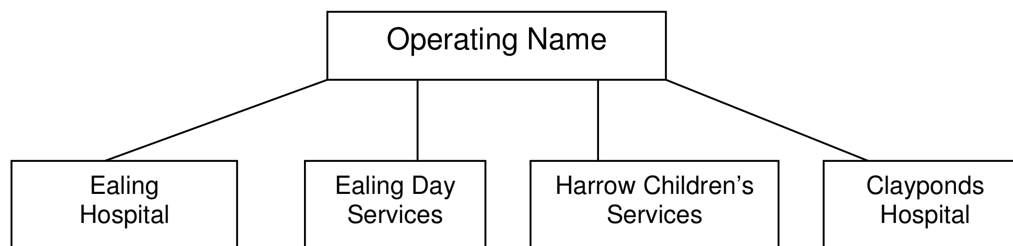
# 7. Name

The choice of the organisation's name is limited by it needs to comply with the following NHS naming protocol, taken from the NHS Brand Guidelines:

- *"Names **must** be clear and descriptive - **not** conceptual or abstract;*
- *Names **must** be written out in full - **not** acronyms or abbreviations;*
- *Names should contain a geographical reference where possible.*

*In the community foundation trust pilot, many organisations preferred the following naming format: X [geographical location] Community Health Services/Trust."*

It is proposed that the organisation has a holding name under which, services may be identified individually within the context of belonging to the larger group. Identifying services in this way will allow flexibility to market individual or specialist services, and provided the opportunity to show borough focus where needed.




Work to develop the name will be incorporated as part of the mission, vision, values and promises work stream, engaging the public, patients, staff and other stakeholders in the following decisions:

- **Preferred geographic locator.**
- **Preferred descriptor.**

The high level of recognition, trust and credibility that the NHS identity carries means that it is important that we use the identity in compliance with the NHS naming protocol, as this makes it clear that we are part of the NHS family. However, there is scope to develop a strap-line that describes our unique local aspiration.

## 8. Message

Internal messages have been developed as a stopgap for use by the communications teams of all four organisations while board decisions about the ICO take place. The messages will be further developed for use with all external and internal audiences. In the interim it is proposed that we will continue to use the following messages, which have been agreed with communications leads in NHS Ealing, NHS Harrow, EHT and EHCS.

Interim messages:

- **We have the opportunity to create a new kind of organisation, which will provide a network of seamless local care by integrating local acute and community services.**
- **We are not taking over or being taken over, all partners are equal. We will have a new purpose; structure and way of operating that combine best practice of all the organisations we have been formed from.**
- **We expect that over the coming three to five years, some new services will join the ICO, and some existing services will leave the ICO.**
- **Ealing and Harrow Community Services is more likely to remain viable with a partner.**
- **Ealing Hospital Trust cannot continue in its present form, as it does not have Foundation Trust status.**
- **Some specialist acute services will be provided at other hospitals where necessary.**
- **Spending on healthcare is unlikely to grow in real terms. We need to find ways to provide more efficient borough based healthcare services that give best value for money while meeting commissioner requirements and patient expectations.**
- **The needs of our community continue to change, while our clinical knowledge grows. We have to be adaptable to enable us to meet the challenges and opportunities this presents.**
- **Staff will be empowered to innovate and improve services in line with the Transforming Community Services agenda.**
- **Staff have been and will continue to be involved in shaping our new organisation.**
- **We have a plan and are clear about our objectives and how we are going to achieve them. Our focus is on improving local healthcare.**

# 9. Stakeholders

## Internal

EHCS has carried out an extensive programme on internal engagement with its staff around the joining together of community services that previously sat with NHS Ealing and NHS Harrow. This has included roadshows, leaders forums, and staff being involved via online surveys in the decision on the new organisation's name. There has also been engagement with staff about the creation of the new ICO. This has included managers and clinicians taking part in the optional appraisals, which informed to the EHCS Board's recommendation to be part on the ICO. Staff have been kept up to date on developments through other internal communications channels that were either already in place at NHS Ealing and NHS Harrow, or have been put in place for EHCS. Union representatives from Ealing and Harrow have been invited to and joined the EHCS's formal Board meeting, where the proposal to create an ICO has been discussed.

To date, NHS Ealing and NHS Harrow staff have been kept abreast of the developing ICO proposal though their established internal communications channels.

40 staff from across EHT were invited to focus groups, led by members of the Leadership Foundation for Higher Education. These independent discussions were to assess the temperature of the organisation; assess how much was known and understood about the strategic situation; and consider how the EHT might involve and engage its staff as it moved into a new transitional phase. EHT's Chief Executive has been conducting face-to-face discussions with staff groups to provide information, get feedback and answer their questions.

In summation:

- Community Services Delivery and Commissioning staff have received information and have been engaged about the separation of community services and commissioning over the last two-years, this work has now started to focus on their separate roles inside and outside the ICO.
- EHT staff have started to be engaged in discussions about the future of the hospital since the withdrawal of the FT application in January 2009. This has included debate about vertical integration and, over the last few months, the creation of the ICO.

### Continuing Engagement with Internal Stakeholders by Groups

#### Group 1 - Front-line Staff

Front-line staff will need to be engaged further and be developed as ambassadors for change. Each individual should be considered as a point of contact with our external audiences. They need to be rehearsed in the reasons for change and the benefits this will bring to our community. We also need to recognise that people will have concerns about their futures, and provide opportunities for them to voice and receive responses to those concerns, and their more general questions. As we are in a state of transition, we may not always be able to provide them with a definitive answer, however we must tell people when we will provide the answers they seek.

**Suggested Tools and Activity Pre-Board decisions 26 November for Group 1:**

- **Cascade briefing to EHCS, NHS Ealing and NHS Harrow staff. Series of meeting with sub-specialties at EHT. Describing:**
    - Background

- Decision Making Process.
    - Staff Involvement to date.
    - Next Steps
    - Q&A's
- **ICO article in each organisation's internal newsletters covering:**
    - Background
    - Decision Making Process
    - Staff Involvement to date.
    - Next Steps
    - Calls to action:
        - Ask questions.
- **ICO Information on each organisation's Intranet:**
    - Background
    - Decision Making Process.
    - Staff Involvement to date.
    - Next Steps
    - Calls to action:
        - Ask questions.
    - Publish responses to questions.
- **ICO article in each organisation's Core Brief:**
    - Advertise dates of EHCS & EHT CEO's Tour.
    - Calls to action:
        - Ask questions.
- **Email campaign to encourage staff to attend EHCS & EHT CEO's Tour.**
- **Advertise dates of EHCS & EHT CEO's Tour in each organisation's internal Newsletters.**
- **Posters advertising EHCS & EHT CEO's Tour in all EHCS & EHT staff areas.**
- **Communications Champions.**
  To help ensure that communications are reaching all staff and that staff have access and are aware of opportunities to engage, we will create a network of communications champions. Each team will have a champion, who will help to ensure that information is disseminated effectively.

  The role must not be forced onto any individual; they should be enthusiastic to take on the role and the additional work required. However, their contribution should be recognised at all levels, and time should be made available by their team managers, so they can carry out this work.

  Communications Champions will champion effective communications within their service area:

    - **Attend monthly meetings throughout the change process where they will be briefed on the following months communications activity.**
    - **Disseminate lateral communications through their area.**
    - **Monitor and feedback on the effectiveness of vertical communications and help identify areas where improvements can be made.**
    - **Make colleagues aware of and encourage them to use opportunities for communicating upwards.**
    - **Help develop understanding of the new organisation's mission and vision among their immediate colleagues.**

This network will be set up immediately, and remain in place until 31 March 2010.

**Suggested Tools and Activity Post-Board decisions 26 November for Group 1:**

- **EHT & EHCS CEOs' Tour.**
  This will be designed to deliver a strong message that EHT and EHCS are starting to work as one organisation.
- **NHS Ealing and NHS Harrow CEOs' Staff Briefing.**
  All staff brief and Q&A session by CEOs' in each organisation once Board decision has been made.
- **EHT & EHCS, NHS Ealing and NHS Harrow CEOs' ICO Open Sessions.**
  Monthly open sessions led by each organisation's CEO where staff can drop in for an ICO 15 minuet update briefing followed by Q&A's session.
- **Announce Board decision in each organisation's Newsletter.**
- **Announce Board decision on each organisation's Intranet.**
- **Announce Board decision in each organisation's Core Brief.**
- **Regular ICO Update in each organisation's Newsletter.**
- **Regular ICO Update on each organisation's Intranet.**
- **Regular ICO Update in each organisation's Core Brief.**
- **Mission, Vision, Values and Promise Development Focus Groups.**
- **Staff questions email. Allowing staff to receive direct answers to their questions.**
- **Feedback to supervisor and line managers sessions.**

**Group 2 - Supervisors and Line Managers**
This group have the most contact and are influential with front-line staff. Their support for the changes that we are implementing has to be gained and maintained. We should not assume that they are good communicators, and provide the appropriate levels of support to help them communicate with and listen to their direct reports. We can also assume that they will be the group who are under most pressure to provide answers to individuals about their futures. Speculation must be discouraged and support provided in dealing with questions from their staff.

**Suggested Tools and Activity Pre-Board decisions in November for Group 2:**

- **Face-to-face briefing led by directors, supported by senior managers.**
  - Briefing on the part they are expected play in the change process.
    - Q&A's
  - Tools to help communicating with staff.
    - Do's and don't when communicating with staff about change.
    - Briefing Note.
    - PowerPoint.
    - Communications Plan.
    - Lines to Take.
    - Feeding information back up the management line.
  - Where can they get help during this process.
  - What will happen during the coming month.

**Suggested Tools and Activity Post-Board decisions 26 November for Group 2:**

- **Monthly face-to-face briefing led by directors, supported by senior managers.**
    - Verbal update.
        - Q&A's
    - Update materials previously distributes.
    - What will happen during the coming month.

**Group 3 - Senior Managers**
Senior managers need to own the messages they are delivering, without their buy-in it will be difficult to get buy-in from their teams. They also need be clear about what information they need to be delivering during each stage of the transformation. They need to be seen to support the case for change and have opportunities to share experiences with their pier group as well as directors.

**Suggested Tools and Activity Pre-Board decisions in November for Group 3:**

- **Informal Meeting with other Senior Managers within their organisation and directors with a short briefing led by their respective CEO's.**
    - ICO Update.
    - The part senior managers will play in the change process.
    - Where can they find help during this process.
    - What next.
    - Tools to help them communicate.
        - Do's and don't when communicating about change.
        - Briefing Note
        - Briefing PowerPoint

**Suggested Tools and Activity Post-Board decisions 26 November for Group 3:**

- **Continuation of Informal Meeting with other Senior Managers. EHCS and EHT A Senior Managers will come together in a joint meeting.**

**Group 4 - Board/Directors**
Non-Executive Directors (NED's) will require regular briefings in addition to their normal contacts as this will be a fast moving project. The weekly project updates that are to be produced by the Project Director will be compiled into a monthly update to supplement their normal information channels. NED's often have unique perspective and the opportunity to test the temperature of external and internal audiences on issues. We will capture this insight through formal and informal contact.

Executive Directors will receive regular updates through their usual channels, as well as receiving the Project Director's update. All communications materials will be share with them for information and they will be involved in specific pieces of work such as developing the new organisations mission and vision.

**All Internal Groups**
- **TUPE Consultation:**
    - Communications Support will be required for the TUPE consultation and transfer process. Details to be agreed.

**Unions**
- **Monthly Briefing Note.**
- **Directors attend JNCC's/JPF's.**

- **Union representatives invited to attend one off briefing after decision. Other briefings to be arranges if required.**
- **Distribute board papers/link to Internet to all union representatives.**
- **HR Workstream Meetings, attended by Union Chair, Sec and CEO's.**

## External

**Consultation and Engagement with the Public**

It is expected that there will not be a requirement to consult with the public, as the changes that are taking place have an organisational focus rather than a service focus. During December 2009, the Overview and Scrutiny Committee will confirm if a formal consultation is required. Once a decision has been made, and if needed a consultation plan and cost schedule will be prepared. However, there is a commitment by the ICO Project Board to be open, and engage fully with external stakeholder, whether or not there is a requirement for formal consultation.

At the time of writing this document, there has been limited reactive or proactive engagement with external audiences.

EHCS has recently completed a piece of work to identify and categorise external stakeholders, putting them into primary, secondary and tertiary groups by scoring them on their ability to:

- **shape the organisation;**
- **help the organisation achieve business success; and**
- **influence the organisation's other stakeholders.**

This work has provided an engagement plan, which has not been put into action due to the change of direction towards the creation of the ICO.

During the visioning workshop with the EHT Leadership Group EHT's key stakeholders were identified.

The next step will be to draw the various engagement work streams together, fill any gaps and produce an integrated external stakeholder map for the ICO project.

Through engagement, we will explain our reasons for change, and provide opportunities for stakeholders to help us develop our ideas in the way that best meets their needs as customers and partners.

While the mapping exercise is being completed, there are external stakeholders that we are able to start to engage.

**Public Networks**

Whether or not there is a requirement to consult, there is a commitment to involve the public in developing the services so that they are appropriate for local people. The organisation that are involved in creating the ICO already posses a network of links into the public through groups such as:

- **LINKs**
- **Partnership Boards**
- **PALS**
- **PPI Steering Committee**
- **Faith Community**
- **Community Leaders**

The case for the ICO will be set out for these groups, and their opinions will be solicited. This will provide opportunities to explain the case for the ICO and gain input into the ICO plan from these groups as representatives of our customers. These groups will also be used as conduits to send information and receive feedback from our customers. Sessions with these groups will either be incorporated into existing forums, or additional opportunities to meet will be created.

Tools, such as PowerPoint presentations, posters, leaflets, briefing notes and feedback mechanisms will be created, to support the onward transfer of the ICO case, and gain in put.

**Internet**
It is proposed that the existing internet sites of NHS Ealing, NHS Harrow and EHT will have a dedicated area that will contain information about the ICO, the benefits it will bring to local people, highlight opportunities to engage as well as provide opportunities for online engagement.

**Local and National Politicians**
The NHS Ealing, NHS Harrow, EHT CEO's will be the primary contacts for this group. They will be offered a face-to-face briefing at the start of the project. This will be supplemented with monthly briefing notes, with the offer of additional face-to-face briefings as required.

Local councillors will be offered the opportunity to attend an Ealing or Harrow focussed briefing event in early December with members of the ICO Project Board. At this event, the CEO's from the ICO organisations will make a short presentation and take questions from the councillors.

Members of the ICO Project Board will offer their attendance at relevant health scrutiny and other committee where there is an opportunity to discuss the impact of these changes and gather views from stakeholders.

**NHS London, Regulators, NHS Confederation DH, other providers and so on.**
Where it does not exist currently, each of these groups will be provided with an ICO Project Board contact, regular briefings and opportunities to feedback.

## 10. Media

The local media will be engaged to communicate with local people. Our aim will be to provide the public with information about the changes that are taking place and the benefits these will bring through trusted local channels. In addition, the information we provide will allow the media to challenge any inaccurate information provided by third parties. Editors will receive a detailed briefing at the start of the project. This will support the media releases and contacts with journalists that take place as the project progresses. Media releases and statements in responses to journalist's questions will be sent out jointly, from all organisations involved in the ICO project.

# 11. Communications Activity Planner – November 2009 to 31 March 2010

| | November | | | | December | | | | January | | | | February | | | | March | | | | April | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Interim Identity Template | | | X | | | | | | | | | | | | | | | | | | | | | |
| Leadership Visioning Workshops | | | | | | | | | | | | → | → | → | → | | | | | | | | | |
| Staff Visioning Focus Groups | | | | | | | | | | | | → | → | → | → | → | → | → | → | | | | | |
| Primary Stakeholder Visioning Engagement | | | | | | | | | | | | | | | → | → | → | → | → | | | | | |
| Developing the Brand Platform. | | | | | | | | | | | | | | | → | → | → | → | → | → | → | | | |
| Develop Visual Identity. | | | | | | | | | | | | | | | | | | → | → | → | → | → | | |
| Develop Implementation Strategy. | | | | | | | | | | | | | | | | | | → | → | → | | | | |
| EHT Sub-specialty Briefings | → | → | → | | | | | | | | | | | | | | | | | | | | | |
| EHT, EHCS, NHS Harrow & NHS Ealing information cascades. | | | → | → | | | | | | | | | | | | | | | | | | | | |
| ICO update article in each organisation's internal newsletters | | | X | | | | | | | | | | | | | | | | | | | | | |
| ICO update Information on each organisation's Intranet | | | X | | | | | | | | | | | | | | | | | | | | | |
| ICO update Information on each organisation's Core Brief | | | X | | | | | | | | | | | | | | | | | | | | | |
| Announce Board decision in each organisation's Newsletter. | | | | X | | | | | | | | | | | | | | | | | | | | |
| Announce Board decision on each organisation's Intranet. | | | | 26 | | | | | | | | | | | | | | | | | | | | |
| Announce Board decision in each organisation's Core Brief. | | | | X | | | | | | | | | | | | | | | | | | | | |
| EHT and EHCS Chief Executives Briefing Tour. | | | | → | → | → | → | | | | | | | | | | | | | | | | | |
| NHS Ealing and NHS Harrow CEO's Staff Briefing | | | | | X | | | | | | | | | | | | | | | | | | | |
| EHT & EHCS, NHS Ealing and NHS Harrow CEO ICO Open Sessions | | | | | | | | | | | | X | | | | X | | | | X | | | | |
| Email campaign to encourage staff to attend CEO's Tour, Briefings and Open Sessions. | | | | X | X | X | X | | | | X | | | | X | | | | X | | | | | |
| Advertise dates of CEO's Tour, Briefings and Open Sessions in each organisation's internal Newsletter. | | | | X | | | | X | | | | X | | | | X | | | | X | | | | |
| Posters advertising CEO's Tour, Briefings and Open Sessions staff areas. | | | X | | | | X | | | | X | | | | X | | | | X | | | | | |
| Face-to-face briefing to supervisors and line managers led by directors, supported by senior managers. | | | | | X | | | | X | | | | X | | | | X | | | | | | | |
| Senior Managers Informal Meeting with other Senior Managers within their organisation and directors with a short briefing led by their respective CEO's. | | | 24 | | | | X | | | | X | | | | X | | | | X | | | | | |
| EHT and EHCS CEO's joint briefing to EHT and EHCS | | | | | | | X | | | | X | | | | X | | | | X | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ED's.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ICO update in each organisation's Newsletter.** | | | | | | | | X | | | | X | | | | X | | | | X | | | | |
| **ICO update on each organisation's Intranet.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ICO update in each organisation's Core Brief.** | | | | | | | X | | | | X | | | | X | | | | X | | | | | |
| **Staff questions email. Allowing staff to receive direct answers to their questions.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Communications Champion.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Project Director Update to project team, copied into ED's. ED's will also receive copies of all other communications.** | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | |
| **Public Engagement through existing networks** | | | | | X | | | | X | | | | X | | | | X | | | | | | | |
| **Updates on EHT, NHS Ealing & NHS Harrow Internets** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Local and National Politicians Face-to-Face Briefings** | | | | X | | | | | | | | | | | | | | | | | | | | |
| **Local and National Politicians Briefing Notes** | | | | X | | | | X | | | | X | | | | X | | | | X | | | | |
| **Local Councillors Group Briefing** | | | | X | | | | | | | | X | | | | | | | | X | | | | |
| **Attendance at Health Scrutiny Committees** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Editor's Briefing** | | X | | | | | | | | X | | | | | | | | X | | | | | | |
| **Journalist Briefings (Media Releases) – Dates to be confirmed.** | | | 26 | | | X | | | X | | | | | | X | | | | | | | | | |
| **Monthly Union Briefing Note.** | | | | X | | | | X | | | | X | | | | X | | | | X | | | | |
| **Directors attend JNCC's & JPF's** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Union representatives invited to attend one off briefing after decision. Other briefings to be arranges if required.** | | | | X | | | | | | | | | | | | | | | | | | | | |
| **Distribute board papers to all union representatives.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **HR Workstream Meetings, attended Staff Side Representatives.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Support communications for TUPE Consultation, dates and costs to be confirmed.** | | | | | | | | ? | | | | | | | | | | | | | | | | |
| **TUPE Information Leaflet** | | | | | | | | ? | | | | | | | | | | | | | | | | |
| **TUPE Consultation Document** | | | | | | | | ? | | | | | | | | | | | | | | | | |
| **TUPE Consultation Response Document** | | | | | | | | ? | | | | | | | | | | | | | | | | |
| **TUPE Consultation Meetings (Managed by HR)** | | | | | | | | ? | | | | | | | | | | | | | | | | |

# ATTACHMENT 8

## Glossary of Terms

**Care Quality Commission (CQC)** - the Care Quality Commission is the new health and social care regulator for England. The aim of the CQC is to ensure better care for everyone in hospital, in a care home and at home. It was established in April 2009 and replaced the Healthcare Commission. They have a statutory duty to assess the performance of health and social care organisations.

**Cooperation and Competition Panel (CCP)** - The CCP helps support the delivery to patients and taxpayers of the benefits of competition by investigating and advising the Department of Health and Monitor on potential breaches of the Principles and Rules of Co-operation and Competition, which can be found on the CCP website.

**Health inequalities** - this is the difference in health status and death rates between different population groups. For example, those with lower socio-economic status, certain geographical areas, those with certain disabilities and certain ethnicities may have worse health than others.

**Intermediate care** – is short-term rehabilitation following an acute illness, offering services that do not require the resources of an acute general hospital, but are beyond the scope of traditional primary care. Services that facilitate transition from medical dependence to functional independence and prevent admission either to hospital or to long-term care.

**Integrated Care** – can be integrated horizontally along the care pathway say between an acute hospital trust and community based services; or horizontally e.g. healthcare with social care combined.

**Integrated Care Organization** (ICO) – and organisation that provides integrated care either vertically or horizontally (see Integrated Care above)

**IT** - Information technology.

**Monitor** - is the independent regulator of NHS foundation trusts. It is independent of central government and directly accountable to parliament. It has 3 main strands to its work: a) determining whether NHS trusts are ready to become NHS foundation trusts; b) ensuring that NHS foundation trusts comply with the conditions they signed up to – that they are well led and financially robust; and c) support to NHS foundation trust development.

**NHS Foundation Trust** - NHS Foundation Trusts have been created to devolve decision-making from central Government control to local organisations and communities so they are more responsive to the needs and

wishes of their local people.

**NHS London (NHSL)** - Strategic Health Authority (SHA) for London – See SHA below.

**Payment by results (PBR)** - the aim of Payment by Results (PbR) is to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions.

**Polysystems -** A poly-system is a clinically led model of care (based on a population of at least 50,000) involving all partners in the network and supported by a primary care led polyclinic hub at its heart. The polysystem can be focused around a polyclinic hub based in the community or on a hospital site.

**Polyclinics -** Polyclinics are designed to make it easier for people to receive better health and social care where and when they need it. They combine GP and routine hospital care with a range of useful wellbeing and support services such as benefits support and housing advice all under one roof. They are designed to give people in London more access to doctors and routine care. Seven polyclinic pilots opened in spring 2009 in Hammersmith & Fulham, Harrow, Hounslow, Lambeth, Redbridge, Tower Hamlets and Waltham Forest.

**Practice-based commissioning (PBC)** - enables GPs and other frontline clinicians to commission the redesign of services that better meet the needs of their patients.

**Primary Care Trust (PCT)** - PCTs control 80% of the NHS budget and commission health services on behalf of their local population.

**Private sector** - organisations and individual proprietors that own and run services for a profit, including care homes for older people, clinics and hospitals, nursing agencies and domiciliary care services.

**Procurement** - procurement is the business management function that ensures identification, sourcing, access and management of the external resources that an organisation needs or may need to fulfill its strategic objectives.

**Professional Executive Committee** ( PEC) The PEC's role is to advise the PCT Board on strategy and to provide insight into the concerns and working lives of healthcare professionals at the sharp-end of delivering primary care to the community.

**Public sector** - The parts of the economy that are not controlled by individuals, voluntary organisations or private companies. This includes national and local government, and government owned firms.

**Quality Outcomes Framework (QOF)** – is a data framework derived from patients attending GP practices e.g. the numbers who smoke or the number of patient's whose blood pressure is under control.

**Resource Accounting & Budgeting** (RAB) - Is a system of planning, controlling and reporting on public spending and budgeting.

**Risk Register** - the risk register is a record of all forms of residual risks, describing the risk in sufficient detail for it to be clearly understood. It assesses the impact and likelihood of the risk happening as well as the action necessary to treat, remove, or transfer the risk.

**Service level agreements (SLAs)** - these are internal NHS agreements between PCTs and NHS Trust on the services to be provided to the local population.

**Strategic Health Authority (SHA)** – SHAs were created by the government to manage the local NHS on behalf of the secretary of state. There are 10 SHAs in England. They manage the NHS locally and are a key link between the Department of Health and the NHS.

**World Class Commissioning** (WCC) – A Department of Health programme to transform the way health and care services are commissioned. World class commissioning will deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. There are four key elements to the programme, a vision for World Class Commissioning, a set of world class commissioning competencies, an assurance system and a support and development framework.

## ATTACHMENTS 9a and 9b

# Finance Schedules

(Spreadsheets  printed separately follow on here)