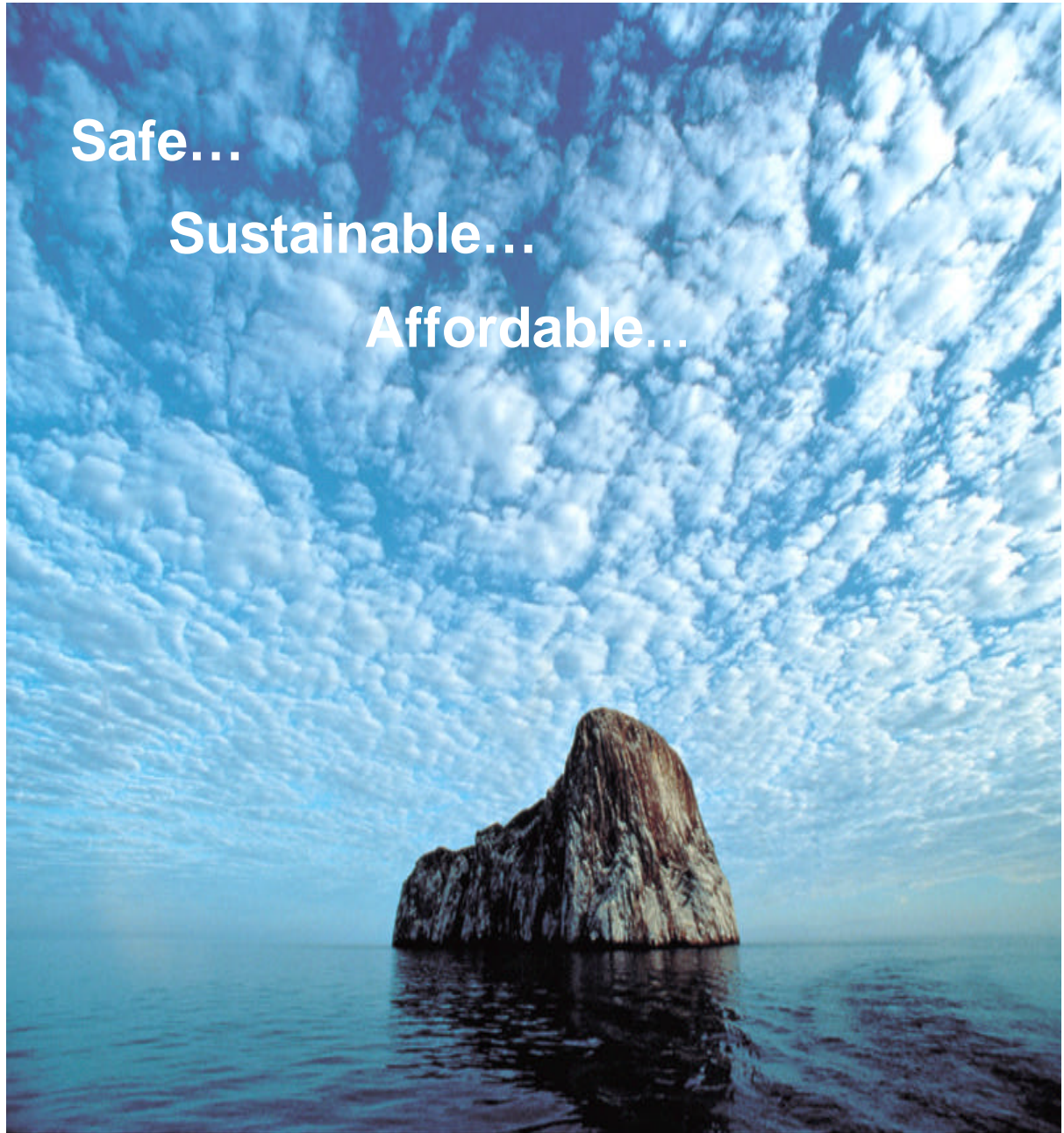


# Isle of Wight – final report for organisational reconfiguration by PricewaterhouseCoopers



# Executive Summary

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## **Background and context**

- 1 We were commissioned by the three key public sector organisations on the Island involved in Health and Social Care to develop and appraise options for organisational structures to take forward work done in the last two years on strategy for the delivery of health and social care. The terms of reference of the review are given in Appendix 1.
- 2 In autumn 2002, under the direction of the Hampshire and Isle of Wight Strategic Health Authority (SHA), the NHS organisations in Hampshire and the Isle of Wight embarked on a process called HealthFit. This process aimed to develop an agreed strategic framework for the development of sustainable, efficient and affordable health services in the local health economy. The two healthcare organisations on the Isle of Wight (IOW), and with the involvement of officers within the Social Services & Housing Directorate of the Isle of Wight Council, developed their own local strategy in response to HealthFit, which is known as the IOW Local Healthcare Strategy.
- 3 The local strategy reflects the changes that the health and social care stakeholders believe are necessary but would require further amendment to ensure it reflected necessary health and social care developments. The focus of the local strategy is service oriented as it identifies changes that are required in areas such as maternity services, mental health, children's services to name a few. One of the key elements of the local strategy is the commitment to joint working. In June 2003 the Council wished to build upon the HealthFit document and agreed with health partners a commitment to joint working with the possibility of organisational change. This was encapsulated in the "statement of intent" which described the desire to see joint delivery of care, and a move to integration of services where possible.
- 4 Following on from the commitment to joint working, it was agreed between the Island health organisations and the SHA that the shape and configuration of Island Health organisations should be reviewed. This decision led to the appointment of external consultants to conduct the review.
- 5 From a national perspective the recently published NHS Improvement Plan "Putting people at the heart of public services", June 2004 emphasises the need to continue to develop high-quality services that are responsive, convenient and personalised. It focuses on improving waiting times even further, ensuring public health is central to the decision making processes and encourages a wide range of service providers to be considered in order to achieve the targets. Linking this to a local agenda which needs to address severe financial challenges means that the design of services and organisations are critical to its success
- 6 We commissioned Bevan Ashford to provide a legal view under existing legal frameworks and current NHS regulations on shortlisted options, solely for the purposes of this review and to support our conclusions. You should take your own legal advice on the final decision.

## **Process for conducting review**

- 7 A steering group was formed in April 2004 and has met 5 times, providing the project with direction and key decisions. The members of the group are given in Appendix 2. We clarified our terms of reference with the steering group, and confirmed that our focus is on organisational design rather than service strategy.
- 8 We then interviewed 18 key stakeholder groups on the Island (Appendix 3), analysed their views on the status quo and options for change, and developed a number of options:

- **Option 1** Do not change the current organisational reconfiguration
- **Option 2** The Isle of Wight Healthcare Trust transfers all primary and community care services (including mental health) to the Isle of Wight Primary Care Trust, leaving a core service of acute focused provision, including ambulance services
- **Option 3** The Isle of Wight PCT transfers all primary and community care services to the Isle of Wight Healthcare NHS Trust, leaving the PCT to focus on its commissioning function. (The PCT would continue to commission public health and GP services)
- **Option 4** The management executive teams of the Isle of Wight Primary Care NHS Trust and Isle of Wight Healthcare Trust merge. This will retain two legal entities (the PCT and Healthcare Trust) until further changes are agreed
- **Option 5** Establish a health & social care trust on the Isle of Wight that includes commissioning functions
- **Option 6** Establish a health & social care trust on the Isle of Wight that does not include commissioning.
- **Option 7** SHA as commissioner of services for the island's population. Establish a Commissioning organisation that is an "out-post" of the SHA, and as part of this the primary care functions transfer into one health service body on the Island
- **Option 8** Establish one Public Service organisation on the Island that encompasses all public services on the Isle of Wight
- **Option 9** Establish a joint commissioning body and develop clinical networks of care so that services are commissioned on a programmed basis. This could mean that service provision is provided from a mixture of Island only, mainland only and Island/mainland services, including the independent sector

At that meeting we also agreed the following evaluation criteria:

**The criteria are as follows:**

- 1. Is the option sustainable?  
(sustainable meaning the ability to ensure long term flexibility and viability of organisational configuration bearing in mind any future changes)**
- 2. Does it provide the potential to achieve economies of scale and reduce costs?**
- 3. Is it consistent with, and assists in the development of, the local healthcare strategy?**
- 4. Does it recognise existing and emerging national policy and planning guidelines for the NHS and Social Care agenda's?**
- 5. What is the ease of transition and timescale for change?**

**Outcomes of discussions and evaluation**

- 9 Three options were discarded early on as they could not sensibly be evaluated using the agreed criteria and scoring:
  - Option 4 – Merging the management of the PCT and the Healthcare Trust – this was the SHAs proposal. We concluded that this could not be evaluated separately as it could only be regarded as a step in a change to a future

organisation state. However clearly this could be a sensible first step for a number of options.

- Option 7 – there were too many similarities to option 6
- Option 8 – one public service body for the Island – although a number of those we talked to saw this long term goal, the level of debate and consultation required to appraise this option was not possible within the time and the agreed terms of reference.

10 At the steering group meeting on 24 May, options were scored. The remaining options following scoring were 5 and 6. Further work has since been done to refine the options, understand the potential legal issues and develop an indicative transition plan. These were presented to the steering group on 22 June and 6 July.

### Short-listed options

11 The two short-listed options are as follows:

- **Option 5** Establish a health & social care trust on the Isle of Wight that includes commissioning functions.
- **Option 6** Establish a health & social care trust on the Isle of Wight that does not include commissioning.

12 Strengths and weaknesses for the two options have much in common. For example, both options will enable greater coordination and integration of services across health and social care. From a patient perspective, this has the potential to provide seamless care and a way of developing a joined up strategy for the longer term provision of care. Similarly, each option provides a logical step to creating a single public services body in the future. This would be innovative and would require a significant shift in policy and legislative changes despite an increasing emphasis given to cross sector working across Government.

13 From a financial perspective, there could be scope to achieve savings. It has not been possible to establish the costs of establishing or operating the new organisation. Based on our experience of organisational change of this magnitude we would expect to see greater efficiencies in areas such as senior management, human resource departments, financial services and information management and technology departments.

14 Option 6 potentially provides a clearer separation for the commissioning function, whereas the lines of commissioning in Option 5 could be less effective if robust arrangements for ensuring transparency and challenge are not in place. This is particularly important in relation to two key NHS initiatives: Patient Choice and Payment by Results.

15 Option 6 was initially developed with a view that commissioning could be either mainland or Island based. For the purposes of this review the concept of commissioning being mainland based has not been developed as it is outside the terms of reference.

## Drivers for the short-listed options

- 16 We considered five key drivers for change in the NHS and on the island to throw further light on the short-listed criteria.

### *Cross Sector working*

- 17 The Office for Public Management (OPM) contributed to the HealthFit process by identifying key forces and drivers for change the NHS.<sup>1</sup> Their identification of cross-sector working as a driver is particularly relevant here. They reported that the Government's policy direction is underpinned by an understanding that the wider determinants of health and the well-being of the population do not lie solely within the remit of health services. In order to address health inequalities it requires cross-sector working at all levels.
- 18 The two options that have been developed will help to achieve a greater degree of cross sector working because there will be a requirement to develop an integrated vision for the provision of health, social care and housing on the Island. This in turn should result in a unified strategic plan that reflects the objectives of all stakeholders involved in the delivery of care. This will provide an innovative model locally (i.e. within the Hampshire & IOW economy) and nationally.

### *CHOICE and Payment by Results*

- 19 These initiatives pose real challenges to the Island in offering realistic options for alternative providers regardless of the organisational configuration option that is chosen. It could be argued that if there is only one organisation that includes commissioning the need for robust commissioning functions will be paramount to ensure that the Patient Choice agenda is implemented and that historical reasons for commissioning do not become the primary driver.
- 20 The local response to HealthFit considers the issues of transport costs for patients who require mainland based treatment. If in the future there is agreement that patient transport costs are met either partially or in full for mainland based treatment, then the Patient Choice agenda takes on a different perspective on the Island and will represent an even stronger challenge from a governance perspective to ensure that commissioning and choice is robust and transparent.

### *Commissioning*

- 21 The key issue for Option 6 will be the establishment of appropriate Governance arrangements. Initially, the PwC project team considered three broad sub-options for the stand alone Commissioning body:
- Entirely stand alone (separate commissioning body)
  - Exist as part of the (expanded) LA Commissioning team
  - Exist as part of the SHA

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<sup>1</sup> Forces and Drivers for change in the provision of healthcare in England, OPM, February 2003

- 22 The key factor in assessing these three alternatives is the issue of Governance and the legality of each. Based on the advice provided to PwC, the position is that:
- Sub-option (ii) would not be possible because the Local Authority cannot commission a wide range of acute health services (e.g. surgery).
  - The third sub-option (iii) is also not possible given the existing statutory framework. Neither is this option seen to fit with the current direction of national or local policy.
- 23 The first sub-option (i), of the entirely stand alone body, is feasible. However, a number of caveats exist regarding how this could be achieved. For example, a PCT which covers the IOW is a statutory requirement therefore one option could be for the PCT to cease providing services itself and commission these services from the Healthcare Trust. Further detail is provided in the section relating to what is legally possible in the main body of the report.

#### *Leadership and creating capacity*

- 24 One of the key issues in bringing about change of this scale will be the ability of the Island Health economy to create additional capacity to help manage the change process. In addition to this there is a need for dynamic leadership that can create the unity of vision that is required to achieve this change.
- 25 Due to constant and demanding pressures, relationships appear strained between executive teams of the Isle of Wight PCT and Isle of Wight Healthcare Trust. Whilst this may be an unfortunate trait in today's NHS, locally, it reinforces our view that the need for single management and leadership of the two healthcare organisations is a necessary step in the process of bringing about organisational change, as long as it can be implemented within existing and future legal frameworks and NHS regulations.

#### *Achieving financial stability*

- 26 One of the key challenges facing the Island is how to achieve financial stability without adversely affecting the quality of patient care. This is a key driver for change. However merely reorganising the organisations will not necessarily result in less cost or indeed contribute to achieving financial balance. The opportunities to achieve management cost savings may be negated by the need to create additional management capacity, at least in the short term. However, a new organisation should lead to greater opportunities for increased efficiency by streamlining processes and introducing new ways of working.
- 27 One factor that will influence the Island's ability to achieve savings could be the implementation of the **European Working Time Directives (EWTD)**. The isolation of the Island may lead to some services potentially becoming unviable unless provided by outreach from larger organisations.
- 28 The EWTD is a directive from the Council of the European Union (93/104/EC) to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted in UK law as the Working Time Regulations, which took effect from 1 October 1998. The impact of implementing this is immense in terms of affordability, improving working lives and maintaining safe levels of working, to name a few key concerns.

## **Organisational transition**

- 29 We have mapped out in Tables 1 and 2 indicative transition plans for Option 5, Option 6 and the integration of Children's Services.
- 30 The following need to be considered in more detail:
- The transition process needs to be funded and have dedicated support. A change programme such as this cannot succeed without having dedicated project management.
  - It will require effective co-ordination of actions across all key stakeholders, while ensuring that existing operations continue unaffected.
- 31 For the changes to have maximum impact, they need to be implemented as soon as possible, recognising legal and recruitment timescales.

## **Integration of children's services**

- 32 During the course of our work, the Children's Services stakeholder group demonstrated a strong, unanimous desire to pursue the integration of Children's services on the Island. The group is very keen that integrated Children's services should not stand alone or be independent from the envisaged Health and Social Care Trust for the Island. While this would certainly appear possible within the scope of the current guidance, specific advice on the acceptability and process for achieving this would need to be sought. Further guidance on the process for establishing Children's Trusts is due to be issued by the DfES in 2004/2005.
- 33 Clearly the timing of integration needs to be considered alongside a number of other factors, including project management capacity, establishing governance arrangements and, importantly the impact integration will have on the Council.
- 34 It would be feasible to develop a Children's Trust in parallel with the formation of a Health & Social Care Trust (HSCT), and consider the integration of this into the new organisation at a later date. The steering group on 22 June agreed that integration of a Children's Trust into the new organisation is unrealistic at the outset of the new organisation, because:
- the new guidance on Children's Trusts will be provided later this year and will require further discussion with DfES, DoH and ODPM in the context of this innovative approach;
  - of the impact on the council's viability and political position through the loss of its two largest service areas namely Social Services and Education; and
  - how members will conduct their corporate parenting responsibility if the service transferred to HSCT.
- 35 This may well impact on the timetable for the development of a Health & Social Care Trust by April 2006. The above issues need to be resolved for Children's Services to become a part of the new organisation. The main focus should be the development of a Children's Trust as part of the Local Authority by April 2006 and integration into the new organisation should be considered at a later date. By this time there will be greater clarity in the governance and reporting arrangements for Children's Trusts.

## Shared Services

- 36 We identified opportunities for maximising the potential of sharing corporate services, notably Finance, HR, IT, and Estates Management. The creation of a new organisation means that services across the Local Authority and health partners could be shared, for example Human Resource departments would lend itself to this and other “backroom” functions with the IM&T departments.
- 37 We identified the existing arrangements for sharing of services and it is clear from this that the majority of services are provided by the Health Care Trust for the PCT and the Corporate Services Department for the Social Services & Housing Department of the IOW Council.
- 38 There appears to be limited use of mainland services in the provision of corporate type functions and we recommend that the potential for testing for value for money needs to be explored further.

## Conclusions

- 39 We recommend that the Steering Group should pursue Option 5 or Option 6.
- 40 It was agreed by the Steering Group on 10 May that we would not identify a preference for either of the two options. It was felt that both options needed to be considered by each respective organisation in light of what we have reported, following which a decision would be made on which way to proceed.
- 41 The decision to review the organisational configuration has been one of the catalysts for change. Stakeholders have suggested, quite forcibly at times, that the need for change is a necessity and that the status quo cannot continue.
- 42 In relation to the integration of children’s services there is clear ambition to integrate fully into the new organisation. Whilst this is positive the timing of this transition and impact on the IOW Council needs to be carefully considered before any firm decision is made. Key stakeholders for children’s services need to embark on further consultation with the IOW Council, PCT and Healthcare Trust to agree the steps required to achieve full integration.
- 43 In summary, we believe that both of the options that have been short-listed could achieve the Island’s original purpose for commissioning this review – that being the reconfiguration of organisations to achieve the Isle of Wight Healthcare Strategy and to deliver safe, affordable and appropriate healthcare.

## Way forward

- 44 In determining the way forward we have made the following recommendations:
  - 41.1 The content of this report should be considered by each respective organisation in order to choose which option to pursue.
  - 41.2 Once each organisation has considered this report, a period of consultation should commence.
  - 41.3 Once a decision has been made in principle based on internal and external consultation, further detailed legal advice should be sought on the legal process to be followed.

- 41.4 Subject to remaining within current and future legal frameworks and NHS Regulations, the NHS in Hampshire & Isle of Wight should strongly consider the appointment of a single CEO and executive management team to provide leadership for the PCT and Healthcare Trust.
- 41.5 Once the CEO is appointed, a Transition Steering Group (TSG) needs to be established to direct and drive the change process.
- 41.6 Specific project management support for the TSG should be identified and appointed.
- 41.7 Project Board should be established to direct the integration of children's services. This Board should encompass senior representation from each of the three principal service areas: Health (PCT and Trust), Education and Social Services.
- 41.8 The Project Board should appoint a Project Manager to drive the day to day progress of the children's integration project.
- 41.9 Project Manager (as in 41.8 above), with oversight from the Project Board and in consultation with the relevant stakeholders, to produce a detailed Project Plan to achieve the integration of Children's services (in a Children's Trust or other body within the LA) by April 2006. The project plan must include key milestones (as set out in the LPS), but also the detailed steps and actions required.
- 41.10 A detailed study should be conducted to explore the development and use of shared service agencies that could support the IOW and to ensure that existing shared service arrangements are providing effective and efficient services.

# Full Report

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# Background and Context

## Introduction

- 45 We were commissioned by the three key public sector organisations on the Island involved in Health and Social Care to develop and appraise options for organisational structures to take forward work done in the last two years on strategy for the delivery of health and social care. The terms of reference of the review are given in Appendix 1.
- 46 In autumn 2002, under the direction of the Hampshire and Isle of Wight Strategic Health Authority (SHA), the NHS organisations in Hampshire and the Isle of Wight embarked on a process called HealthFit. This process aimed to develop an agreed strategic framework for the development of sustainable, efficient and affordable health services in the local health economy. The two healthcare organisations on the Isle of Wight (IOW), and with the involvement of officers within the Social Services & Housing Directorate of the Isle of Wight Council, developed their own local strategy in response to HealthFit, which is known as the IOW Local Healthcare Strategy.
- 47 The local strategy reflects the changes that the health and social care stakeholders believe are necessary but would require further amendment to ensure it reflected necessary health and social care developments. The focus of the local strategy is service oriented as it identifies changes that are required in areas such as maternity services, mental health, children's services to name a few. One of the key elements of the local strategy is the commitment to joint working. In June 2003 the Council wished to build upon the HealthFit document and agreed with health partners a commitment to joint working with the possibility of organisational change. This was encapsulated in the "statement of intent" which described the desire to see joint delivery of care, and a move to integration of services where possible.
- 48 Following on from the commitment to joint working, it was agreed between the Island health organisations and the SHA that the shape and configuration of Island Health organisations should be reviewed. This decision led to the appointment of external consultants to conduct the review.
- 49 From a national perspective the recently published NHS Improvement Plan "Putting people at the heart of public services", June 2004 emphasises the need to continue to develop high-quality services that are responsive, convenient and personalised. It focuses on improving waiting times even further, ensuring public health is central to the decision making processes and encourages a wide range of service providers to be considered in order to achieve the targets. Linking this to a local agenda which needs to address severe financial challenges means that the design of services and organisations are critical to its success.

## Key challenges

- 50 The key challenges in delivering organisational reconfiguration are:

**Turning commitment into reality** – it is encouraging that Island health and social care partners have been reviewing how services are currently provided and the options for change. Significantly in June 2003 a joint statement of intent was agreed that demonstrates a commitment to joint working. The challenge is to ensure that this becomes reality by testing traditional boundaries in order to provide a service that meets the needs of patients.

**Accountability framework** – one of the issues that will need to be carefully considered is accountability for design and commitment of resources, and ultimately who will any new organisation be accountable to. The concept of working in partnership is generally positive until it reaches a point where accountability for expenditure and commitment of other resources has not been clearly defined and agreed, and is open to challenge.

**Political acceptability** – one test relates to the political acceptability of any proposal for change, at a national and local level. The responses from early consultation exercises will need to be taken into account when agreeing the preferred option.

**Financial recovery** – the desire to provide and organise services in the best way possible has to be set against the severe financial difficulties facing the Island. The need to achieve financial balance requires a sensible approach to organisational change being adopted so that it is integrated with the financial recovery plans currently being established.

**Balance between effectiveness and community** – it will be important to ensure that the balance between the provision of effective care and maintaining a community focus is achieved. This will involve ensuring that the best effective care in terms of safety, affordability and sustainability is provided by testing out service provision options that include mainland based care and independent sector providers.

### **Early context of developing options**

- 51 We established a range of options based on our own research and the views of those we have listened to. The results of these findings are described later in the report.
- 52 Before arriving at these options we considered issues around integration of **children's services**. Given that it is a distinct area of service for a particular client group, we believed that it did not constitute an organisation reconfiguration option, because it would not be viable as a stand alone organisation. The integration of children's services is described later in the report.
- 53 Similarly, we also considered the creation of a **Foundation Trust**. Currently the national agenda has included the creation of Foundation Trusts based on existing configuration of acute service providers. The achievement of Foundation Trust status can be applied for when performance meets required standards and regulatory approval. In considering the options we were mindful of how the future organisational configuration may lend itself to achievement of Foundation Trust status.
- 54 If and when national policy changes regarding the Foundation Trust agenda the development of a new organisation on the Island should reflect this where possible and practical. This report does not in anyway preclude changes to be made in the development of a new organisational model in light of new national policy decisions, changes in legislation or NHS/Social Care regulations.

# Process of conducting the review

## Introduction

55 Our work started on 12 April 2004 following an initial meeting with the Director of Strategy on 8 April to discuss the proposal in more detail and to clarify our approach to the review. During this meeting we agreed that we would deliver our work against the following milestones:

- provide an interim report to highlight our early thoughts and key findings
- conduct a workshop that would focus on short-listing options
- production of a final report

56 In the early phases of our work we heard a considerable debate about service development strategy. This led us to consider whether organisational reconfiguration is the key priority.

57 We sought therefore to clarify the nature of our project on a number of occasions with respect to the development of options. The Steering Group on 10 May confirmed that we were commissioned to look at organisational reconfiguration at a strategic level, and not service strategy. This is an important clarification as it assists in managing the expectations of the steering group, relevant organisations and stakeholder groups.

## Stakeholder engagement

58 We met with a wide range of stakeholders and sought views on the options they believe could work, and the criteria that should be used to assess options. A briefing paper was produced for the groups we met and included the following questions:

- What is positive about the existing organisational configuration?
- What would you like to change?
- Is the current configuration fit for achieving the strategy set out in HealthFit?
- What option/s do you think exist for organisational reconfiguration?
- What criteria do you think is important when short-listing option/s?
- What are the barriers to change?
- What are the levers to change?

59 We considered a range of documentation from the four organisations involved and have used this to help us with our initial views.

## Communication

60 We provided input and advice on the communication briefing documents that were submitted to staff by the organisations involved. We also established a confidential e-mail communications channel for staff of the stakeholder groups so that they could express views in confidence. This would remain completely confidential and any views expressed would be used in summary format as part of our findings. The e-mail address was personalised for this project as follows: [iow.reviewoptions@uk.pwc.com](mailto:iow.reviewoptions@uk.pwc.com) . The responses to the confidential e-mail were limited. In total 8 e-mails were received.

## Project Management

61 A steering group was established to provide us with direction and guidance on issues that arose during our work, and to participate in agreeing the evaluation criteria and short listing options. The group membership was as follows:

- Mr Mike Fisher, CEO Isle of Wight Council (Chair)
- Mr Graham Elderfield, CEO Isle of Wight Healthcare NHS Trust
- Mr David Crawley, CEO Isle of Wight PCT
- Mr Glen Garrod, Director of Social Services and Housing
- Mr Mark Price, Director of Strategy, Isle of Wight PCT/Healthcare NHS Trust
- Hampshire & Isle of Wight Strategic Health Authority representation
- PricewaterhouseCoopers representation

62 Four meetings were held on 21 April, 10 May, 3 June and 22 June, with a final meeting on 6 July to agree final amendments to the report and sign off the project.

## Option Short-listing criteria

63 The criteria for evaluating options were developed and discussed at the Steering Group meeting on 10 May 2004. These were developed through our own research and from the views of people we have spoken with. Following discussion at the Steering Group meeting on 24 May 2004 the following option evaluation criteria were agreed:

### The criteria are as follows:

1. **Is the option sustainable?** (sustainable meaning the ability to ensure long term flexibility and viability of organisational configuration bearing in mind any future changes)
2. **Does it provide the potential to achieve economies of scale and reduce costs?**
3. **Is it consistent with, and assists in the development of, the local healthcare strategy?**
4. **Does it recognise existing and emerging national policy and planning guidelines for the NHS and Social Care agenda's?**
5. **What is the ease of transition and timescale for change?**

- 64 In addition to the above criteria, there are two further secondary issues that need to be considered at a high level. These are, the legal status of any proposed change (i.e. an option may be developed that requires a change to legislation), and whether it provides potential for benefiting service delivery.
- 65 The short-listing took place on 24 May 2004 and two options were identified as potentially providing the best solutions to help the Island deliver its healthcare strategy.
- 66 At the Steering Group Meeting on 3 June we discussed a potential time frame for implementing a new organisation and it was agreed that the earliest that any new organisation could be created would be 1 April 2006. On that basis we were asked to use our remaining time to focus on the transition process up to 2006, rather than develop each of the options in more detail.

# Option Development, Short listing & outcomes

## Introduction

67 During the course of our work with the stakeholders we gathered views on the range of options that could be considered. In turn we developed these into 9 principal options that could be considered by the Steering Group in advance of short-listing. These are described below. The strengths and weaknesses of each are outlined in Appendix 4:

## Options

### **Option 1 Do nothing regarding organisational reconfiguration**

'Do nothing', is always an option that needs to be considered, recognising that there is some 'good fit' characteristics within the current arrangements. However, in doing nothing about organisational reconfiguration, further work on the development of the healthcare service strategy and development and achievement of financial recovery plans should continue.

### **Option 2. The Isle of Wight Healthcare Trust transfers all primary and community care services (including mental health) to the Isle of Wight Primary Care Trust, leaving a core service of acute focused provision, including ambulance services.**

The acute trust would focus on elective and emergency services provided from the Isle of Wight. The PCT would continue to have a commissioning role and be responsible for providing primary and community services, and mental health. Social services would remain as a separate entity and interact with both; not excluding the option of the development of service integration.

### **Option 3. The Isle of Wight PCT transfers all primary and community care services to the Isle of Wight Healthcare NHS Trust, leaving the PCT to focus on its commissioning function. (The PCT would continue to commission public health and GP services)**

The healthcare trust would provide all healthcare services except for GP and public health services. The PCT would focus solely on their commissioning role. Social services would remain as a separate entity and interact with both; not excluding the option of the development of service integration, and further use of Section 31.

### **Option 4. The management executive teams of the Isle of Wight Primary Care NHS Trust and Isle of Wight Healthcare Trust merge. This will retain two legal entities (the PCT and Healthcare Trust) until further changes are agreed**

A single management team for the PCT and Healthcare trust with no change to the management of services or Trust Boards. One Management executive team would fulfil the duties required for both organisations. Social services would remain as a separate entity and interact with both; not excluding the option of the development of service integration.

**Option 5. Establish a health, social care & housing trust on the Isle of Wight that includes commissioning functions.**

Bringing together areas of health, social care (both adults and children & families services) and housing under one organisation, which includes all care groups.

**Option 6. Establish a health, social care & housing trust on the Isle of Wight that does not include commissioning.**

Bringing together areas of health, social care (adult services) and housing under one organisation, which includes all care groups, with the exclusion of the commissioning function.

**Option 7. SHA as commissioner of services for the island's population. Establish a Commissioning organisation that is an "out-post" of the SHA, and as part of this the primary care functions transfer into one health service body on the Island**

All health services will be provided by one island-based provider organisation. Social services would remain as a separate entity and interact with both; not excluding the option of the development of service integration.

**Option 8. Establish one Public Service organisation on the Island that encompasses all public services on the Isle of Wight**

Provider and commissioner of all services currently being provided/ commissioned by the PCT, healthcare trust and the local authority in one organisation. This would provide a potential long-term vision for the Island and offer a model of how a total community could function for the good of local citizens.

**Option 9. Establish a joint commissioning body and develop clinical networks of care so that services are commissioned on a programmed basis. This could mean that service provision is provided from a mixture of Island only, mainland only and Island/mainland services, including the independent sector.**

This option considers the concept of virtual organisations. It would require a radical approach to commissioning services that are managed by a variety of providers of which some would be mainland based and others Island based. This would require a significant development and advancement in the range of clinical networks that exist.

It would also mean that each existing organisation would no longer exist on the Island. Staff at each Trust would be "managed" by the clinical network. The Hospitals that currently exist would merely serve as a facility from which services are provided, which is much as they are now.

**Short-listing – Scores and outcomes**

- 68 Following the development of options, and agreement of the evaluation criteria, the short-listing of options took place. This process consisted of input from all representatives from the Steering Group.

The short-listing methodology is described below:

<i>Shortlist Criteria</i>	<i>Description</i>	<i>Weighting</i>
<i>Sustainability</i>	<b>The ability of the island to ensure long term flexibility and viability of organisation configuration bearing in mind any future likely changes</b>	<b>40</b>
<i>Local strategic fit</i>	<b>Consistent with and helps develop the Island healthcare strategy to provide a more responsive service</b>	<b>25</b>
<i>National strategic fit</i>	<b>There is potential to recognise, and influence existing and emerging national policy.</b>	<b>20</b>
<i>Potential to achieve economies of scale and reduce costs</i>	<b>Potential to achieve greater efficiency and effectiveness in the public sector on the IOW</b>	<b>10</b>
<i>Ease of transition and timescale for change</i>	<b>The ease of transition to a new structure is relatively smooth within a reasonable timescale</b>	<b>5</b>

69 The impact that each option has on these criteria will be measured using a scoring system:

- High = fully meets criteria / very easy to achieve = 5 points
- Medium = partially meets criteria / achievable, but with some difficulty = 3 points
- Low = doesn't meet criteria / major difficulties to achieve = 1 point

70 In discussing the options that were developed with the Steering Group, it became clear that there were some that could not be included in the scoring and short-listing process. There were three that fell into this category:

- **Option 4** - The management executive teams of the Isle of Wight Primary Care NHS Trust and Isle of Wight Healthcare Trust merge. This will retain two legal entities (the PCT and Healthcare Trust) until further changes are agreed
- **Option 7** - SHA as commissioner of services for the island's population. Establish a Commissioning organisation that is an "out-post" of the SHA, and as part of this the primary care functions transfer into one health service body on the Island
- **Option 8** - Establish one Public Service organisation on the Island that encompasses all public services on the Isle of Wight

The reasons for excluding these from the short-listing process are described below:

#### **Option 4 – development of a single management team**

71 The National Health Service in Hampshire and the Isle of Wight has embarked upon a development programme entitled Beyond HealthFit that seeks to improve the health and well-being of local people in line with the NHS Plan through sustainable, affordable, patient-

focused services that meet the health needs of communities. Part of this process includes the development of single integrated management team for a cluster of two or more primary care trusts and, for the purposes of the Island, the PCT and the Isle of Wight Healthcare Trust.

- 72 Mindful of the potential for this programme to prejudice the work that had already been progressed between Health and Local Government on the Island, it was agreed that the Isle of Wight would be excluded from the refocusing leadership initiative.
- 73 However, contingent on the pace of implementation of the recommendations from this report, Island health services will consider the bringing together of the two management executive teams of the Healthcare Trust and PCT, within existing and future legal frameworks and NHS regulations, to create one executive team, with one CEO. It would mean that until further organisational change occurs, the PCT and Healthcare Trust would remain in situ as legal entities in their own right, with their own Boards.
- 74 Our view, regardless of the SHA proposal, is that this is a sensible first step in bringing about longer term organisational change, as long as it can be achieved within existing legislation. As this is seen as a step in the process, it could not have been regarded as an organisational change option, and therefore was excluded from the short-listing process.

**Option 7-** This was too close to option 6 to be worthy of separate analysis and it was agreed to remove this.

**Option 8 A single public service organisation that encompasses all public services on the Isle of Wight.**

- 75 During the process of listening to stakeholders and understanding their views on organisational reconfiguration, one potential option emerged. This was the development of a single public service organisation that encompasses **all** public services on the Isle of Wight.
- 76 As we continued our communications with various stakeholder groups, this option was identified as desirable as a potential long term vision by some stakeholders. On that basis we included it in the long list of options for discussion at the short listing session during May 2004 with the project steering group.
- 77 In order to develop this as an option, we would have to conduct a far greater range and depth of analysis across all existing public services on the Island and because of this, it was agreed that this was beyond the terms of reference that we have been commissioned against, and should not be included in any formal option appraisal process. However, it was felt that as this represented an innovative and new model of providing public services to the citizens of the Island, it does merit some investigation.
- 78 On that basis we conducted some high level analysis of the strengths and weaknesses in order to demonstrate the potential viability of this as a future vision for the Island community. In addition to this we have set out below some of the key challenges that the Island will face in turning this long term vision into reality.
- 79 The respective strengths and weaknesses are highlighted below:

Strengths	Weaknesses
Innovative model that may attract central funding to develop this approach	Ability to integrate services where organisations have different cultures may hinder successful integration
Will maintain focus on service delivery on the island and will ensure that the island has a voice at regional government level	No service strategy in place to support the integration agenda
Will require an incremental approach that can build on an action research approach – evaluation throughout as you go - which will ensure buy in and reflection of progress to date	Will require significant political support from all organisation, not currently in place
Should ensure greater economies of scale for the island	Will require primary legislation. There will also be a need for clear lines of accountability to different Government Departments.
Greater opportunity for the island to control its own destiny, and helps to provide a strategic voice for the Island within a regional context.	Will require an evolutionary approach and may not be sustainable against s backdrop of significant financial pressure
Improved democratic approach on the Island	

## Key Challenges

80 In turning this long term vision into reality there are many issues that will need to be addressed. We have highlighted below two key areas that will need to be considered:

- Creating a shared vision and joined up strategic direction

Currently there does not appear to be a unified vision on the creation of one public service organisation. To create this there needs to be open debate amongst all key stakeholders to understand the potential benefits of having one public body, and how this will impact upon the citizens of the Island. There will be a need for ongoing development of partnerships and the need to understand how the national versus local agenda for change can become aligned.

The pressures on each organisation are such that there is a tendency to become narrow in outlook and focus on delivering against key targets and statutory requirements. A further challenge would be creating a local joined up public service that is accountable to separate Central Departments (e.g. DoH, DfES).

Overall this challenging area needs to be addressed by the Island's Local Strategic Partnership, known locally as Island Futures.

- Cultural shift

There will need to be a significant shift in culture despite clear evidence that Island citizens want to maintain control and have local accountability. Within the existing organisations based on what we have seen and heard during this review, there is a difference in culture that will require change. It is possible, but will take time.

## Remaining Options

81 The remaining options were then scored and the outcome is described below. From the table below it is clear that option 5 & 6 have scored much higher than the other options:

Position	Option	Total points
1	5	450
2	6	380
3	3	300
4	9	260
5	2	160
6	1	120

**Option 5: Establish a single health, social care and housing organisation on the Isle of Wight that includes commissioning functions scored 450 points**

**Option 6: Establish one health and social care and housing organisation on the Isle of Wight that does not include commissioning. Commissioning would become a separate organisation. This scored 380 points.**

Each of these options to varying degrees will provide a sustainable solution regarding the organisational fit that is required to achieve the service strategies that are being developed. In addition they represent the best fit for achieving local and national policy regarding the need to achieve financial stability (i.e. one organisation should have greater opportunity to identify and achieve areas where efficiencies can be made). With reference to the transition process, both options are achievable – however, the magnitude of change should not be underestimated and this will need to be considered alongside the day to day running of the organisations and availability of management capacity to deliver the change programme.

The following sections of the report describe the two options in more detail.

# Short-listed options

## Introduction

82 Following short-listing, the two options described below emerged as front-runners to achieve sustainable change on the Island. Each option provides its own set of strengths and weaknesses. These are described below:

## Option 5

83 Option 5 is the establishment of a single health, social care and housing organisation on the Isle of Wight that includes the commissioning function.

## Strengths and Weaknesses of option 5

Strengths	Weaknesses
Meets the integration agenda	Purchaser and provider in one organisation, which could result in ineffective commissioning, unless a strong commissioning function is developed
Enables care to be delivered by care pathways – e.g. facilitates chronic disease management	Difficult to integrate services where organisations have different cultures and external pressures (i.e. government targets, inspection regimes etc)
Meets the wider Government agenda of cross sector working	Complex, diverse organisation to manage
Provides a basis from which to further integrate services and supports the single assessment process	Impact on the other Council services could be detrimental. Will the Council be viable?
Improved seamlessness of care i.e. movement through organisations	Diseconomies of scale still remain
Assists in the development of ‘cradle to grave’ services	Remains insular
Potential to reduce management costs	Could be regarded as limiting patient choice if commissioning does not test out all alternative provider opportunities
Improved commissioning of services as commissioning and some provider services would be within one organisation, with the opportunity to put the user/carer at the centre of commissioning – improved patient centred care	Patient Choice being maintained with a local provider could result in high costs if the new organisation is not willing to make difficult decisions over patient choice options
Supports Patient Choice by maintaining a local provider	
New service model as it incorporates housing	

## Option 6

84 Option 6 is the establishment of one health, social care and housing organisation on the Isle of Wight that does not include commissioning.

85 The provision of health, social care and housing services would sit under one organisation while the commissioning of these services would sit under another, completely separate

organisation. There are a number of options for the commissioning function, for example positioned within the local authority, or have this function operated by an independent organisation.

### Strengths and Weaknesses of Option 6

Strengths	Weaknesses
Meets the integration agenda	If commissioning is taken off the island commissioning becomes more remote and may not meet the needs and aspirations of the island's population
Enables care to be delivered by care pathways – e.g. facilitates chronic disease management	Ability to integrate services where organisations have different cultures
Meets the wider government agenda of cross sector working and encourage greater patient choice	Potential for there to be increased, continued, tensions between the commissioners and providers
Improved seamlessness of care i.e. movement through organisations	Impact on the other Council services could be detrimental. Will the Council be viable?
Assists in the development of 'cradle to grave' services	Diseconomies of scale still remain
Reduced management costs	Establishment of a separate commissioning body is likely to increase costs
Greater focus on the commissioning and provision of services as they are in two separate organisations	No change from what is in place now regarding the number of organisations
New service model as it incorporates housing	

### Conclusions

- 86 Strengths and weaknesses for the two options have much in common. For example, both options will enable greater coordination and integration of services across health and social care. From a patient perspective, this has the potential to provide seamless care and a way of developing a joined up strategy for the longer term provision of care. Similarly, each option provides a logical step to creating a single public services body in the future. This would be innovative and would require a significant shift in policy and legislative changes despite an increasing emphasis given to cross sector working across Government.
- 87 Option 6 potentially provides a clearer separation for the commissioning function, whereas the lines of commissioning in Option 5 could be less effective if robust arrangements for ensuring transparency and challenge are not in place. This is particularly important in relation to two key NHS initiatives – Patient Choice and Payment by Results.

- 88 Option 6 was initially developed with a view that commissioning could be either mainland or Island based. For the purposes of this review Option 6 has been only considered this as an Island based model in accordance with the terms of reference.
- 89 There is likely to be scope to achieve financial savings. It has not been possible to establish the costs of establishing or operating the new organisation. Based on our experience of organisational change of this magnitude we would expect to see greater efficiencies in areas such as senior management, human resource departments, financial services and information management and technology departments.
- 90 One of the constraints surrounding the consideration of potential options is that the cost of the preferred option must cost less than the current organisation configuration. The steering group interpreted this to mean that the management costs of the preferred option must cost less than the management costs of the current organisation configuration.
- 91 Together with the Finance Directors of each of the current organisations we determined that the management costs should broadly include the total pay costs of the Board and the tier of staff that report to Board members. In total for the three organisations combined it amounted to £2.5 million. By reducing the number of organisations, a saving in management costs would be expected. Of the two options, Option 5 would appear to offer the greater potential to cost less than existing organisations and option 6, as there could be an opportunity to reduce management costs and streamline processes and systems.

# What are the drivers in relation to each option?

## Introduction

- 92 This section briefly describes five key drivers which will impact on achieving organisational change via either of the options, and act as levers for increasing productivity and performance.

### *Cross Sector working*

- 93 The Office for Public Management (OPM) contributed to the HealthFit process by identifying key forces and drivers for change the NHS.<sup>2</sup> Their identification of cross-sector working as a driver is particularly relevant here. They reported that the Government's policy direction is underpinned by an understanding that the wider determinants of health and the well-being of the population do not lie solely within the remit of health services. In order to address health inequalities it requires cross-sector working at all levels.
- 94 The two options that have been developed will help to achieve a greater degree of cross sector working because there will be a requirement to develop an integrated vision for the provision of health, social care and housing on the Island. This in turn should result in a unified strategic plan that reflects the objectives of all stakeholders involved in the delivery of care. This will provide an innovative model locally (i.e. within the Hampshire & IOW economy) and nationally.

### *CHOICE and Payment by Results*

- 95 These initiatives pose real challenges to the Island in offering realistic options for alternative providers regardless of the organisational configuration option that is chosen. It could be argued that if there is only one organisation that includes commissioning the need for robust commissioning functions will be paramount to ensure that the Choice agenda is implemented and that historical reasons for commissioning do not become the primary driver.
- 96 The local response to HealthFit considers the issues of transport costs for patients who require mainland based treatment. If in the future there is agreement that patient transport costs are met either partially or in full for mainland based treatment, then the Choice agenda takes on a different perspective on the Island and will represent an even stronger governance challenge to ensure that commissioning and choice is robust and transparent.

### *Commissioning*

- 97 The key issue for Option 6 will be the establishment of appropriate Governance arrangements. Initially, the PwC project team considered three broad sub-options for the stand alone Commissioning body:
- i) Entirely stand alone (separate commissioning body)

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<sup>2</sup> Forces and Drivers for change in the provision of healthcare in England, OPM, February 2003

ii) Exist as part of the (expanded) LA Commissioning team

iii) Exist as part of the SHA

98 The key factor in assessing these three alternatives is the issue of Governance and the legality of each. Based on the advice provided to PwC, the position is that:

99 Sub-option (ii) would not be possible because the Local Authority cannot commission a wide range of acute health services (e.g. surgery). The third sub-option (iii) is also not possible given the existing statutory framework. Neither is this option seen to fit with the current direction of national or local policy.

100 The first sub-option (i), of the entirely stand alone body, is feasible. However, a number of caveats exist regarding how this could be achieved. For example, a PCT which covers the IOW is a statutory requirement therefore one option could be for the PCT to cease providing services itself and commission these services from the Healthcare Trust. Further detail is provided relating to what is legally possible.

101 A consistent theme across both options and for PCTs nationally, is the issue of attaining sufficient management capacity and skills to achieve effective commissioning. Neither of the two options presented here will deliver effective and robust commissioning if these two factors are not addressed.

#### *Leadership and creating capacity*

102 One of the key issues in bringing about change of this scale will be the ability of the Island Health economy to create additional capacity to help manage the change process. In addition to this there is a need for dynamic leadership that can create the unity of vision that is required to achieve this change.

103 Due to constant and demanding pressures, relationships appear strained between executive teams of the Isle of Wight PCT and Isle of Wight Healthcare Trust. Whilst this may be an unfortunate trait in today's NHS, locally, it reinforces our view that the need for single management and leadership of the two healthcare organisations is a necessary step in the process of bringing about organisational change, as long as it can be implemented within existing and future legal frameworks and NHS regulations.

#### *Achieving financial stability*

104 One of the key challenges facing the Island is how to achieve financial stability without adversely affecting the quality of patient care. This is a key driver for change. However merely reorganising the organisations will not necessarily result in less cost or indeed contribute to achieving financial balance. The opportunities to achieve management cost savings may be negated by the need to create additional management capacity, at least in the short term. However, a new organisation should lead to greater opportunities for increased efficiency by streamlining processes and introducing new ways of working.

105 One factor that will influence the Island's ability to achieve savings could be the implementation of the **European Working Time Directives (EWTB)**. The isolation of the Island may lead to some services potentially becoming unviable unless provided by outreach from larger organisations.

106 The EWTD is a directive from the Council of the European Union (93/104/EC) to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted in UK law as the Working Time Regulations, which took effect from 1 October 1998. The impact of implementing this is immense in terms of affordability, improving working lives and maintaining safe levels of working, to name a few key concerns.

# What is legally possible?

## Introduction

- 107 We commissioned Bevan Ashford for the purposes of this review to describe what is possible within the existing legal framework for each of the two options. You should obtain your own legal advice on the final decision.
- 108 It should also be noted that this report does not preclude any future changes to organisational structures and that new legislation and NHS regulations need to be considered as they are developed.

## Joint Management Teams

- 109 One of the areas that we asked Bevan Ashford to consider related to the combination of Healthcare Trust and PCT executive management teams, because it would be a sensible first step in the overall transition process. We are advised that within the existing legal frameworks and regulations there are a limited number of posts that can be common to a PCT and Healthcare Trust. These are:
- Chief Executive Officer
  - Director of Finance

However, there are non-voting board director positions that may be considered possible for the purposes of common posts to both PCT and the Healthcare Trust. For example, director of operations, director of planning, director of strategy etc.

- 110 Our proposed way forward reflects the advice given to us. As requested by the Steering Group on 22 June 2004, we have provided the full background workings under separate cover.

## The Two short-listed options:

### Existing legislative framework, structures and governance

- 111 Before discussing each of the options, it is important to consider the powers available to the NHS and local authorities who enable them to integrate and/or transfer their respective functions.
- 112 Section 31 of the Health Act 1999 and the Partnership Regulations<sup>3</sup> (the “Section 31 powers” or “Health Act Flexibilities”) enable NHS bodies (PCTs and NHS Trusts) to enter into partnership arrangements with local authorities for the exercise of prescribed functions. They also enable NHS bodies and local authorities to establish pooled funds.
- 113 There are a number of pre-conditions for the use of the Section 31 powers as follows:

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<sup>3</sup> NHS Bodies and Local Authorities Partnership Arrangements Regulations 1990 (as amended)

- the parties must consult those persons who appear to be affected by the proposed arrangements;
- the proposals must fulfil the objectives of the Health Improvement/Local Delivery Plan;
- the proposals must be likely to lead to an improvement in the way the parties functions are exercised;
- there must be a written agreement containing specific details (the Partnership Regulations set out the minimum requirements).

114 Building on the Health Act Flexibilities, Section 45 of the Health and Social Care Act 2001 enables an NHS Trust or a PCT which is already or is proposing to exercise local authority functions using the Section 31 powers to be designated as a Care Trust.

115 A Care Trust will always be an NHS organisation. Its structure and governance can be based on either:

- a Primary Care Trust model; or
- an NHS Trust model.

116 The membership of a Care Trust Board is prescribed by Regulations<sup>4</sup> and must include at least one executive/officer member with experience in local authority functions and at least one non-executive local authority member.

117 Care Trusts have the advantage of creating a stable organisational framework for long-term service and organisational continuity with a clear focus on the integrated commissioning and/or provision of care.

118 A Section 31 agreement, between the NHS body and local authority, underpins the establishment of a Care Trust. The agreement will document, amongst other things, the functions to be exercised and services to be commissioned and/or provided by the Care Trust and the obligations of and relationship between the parties.

119 A final point worthy of note in the context of the legislative framework is the requirement that the areas for which Primary Care Trusts are established must together comprise the whole of England.<sup>5</sup> In other words, there must be a Primary Care Trust covering the Isle of Wight. This would, however, include a Care Trust based on the Primary Care Trust model.

**Option 5 – To establish one health, social care and housing organisation on the Isle of Wight that includes commissioning functions**

120 Establishing a single organisation would require the merger of the Trust and the PCT.

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<sup>4</sup> National Health Service Trusts (Membership and Procedure) Regulations 1990 (as amended) for a Care Trust based on the NHS Trust model;

Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 (as amended) for a Care Trust based on the PCT model.

121 The only basis upon which this could be achieved would be for the services provided by the Trust to be provided by the PCT and the Trust dissolved. This is because, as discussed above at paragraph 113, there is a legal requirement for a PCT covering the Isle of Wight. In addition, the Trust has no power to carry out a number of the PCT's functions.

122 In order to integrate health, social care and housing, the Section 31 powers must be used. These powers allow the PCT to exercise the Council's social services and housing functions in conjunction with its own NHS functions, both in relation to commissioning and provision of services. A Section 31 agreement documenting the integration arrangements would be required.

123 The Council and PCT could either:

- (a) at the same time as, and as part of the process of, integrating their functions; or
- (b) once their functions have been integrated,

consider moving to Care Trust status based on the PCT Care Trust model. This would then create a single organisation on the Isle of Wight responsible for the commissioning and provision of NHS, social care and housing services.

#### **Establishing a separate commissioning body**

#### **Option 6 – Establish one health, social care and housing organisation on the Isle of Wight that does not include commissioning. This becomes a separate body.**

124 As discussed above, a Primary Care Trust which covers the Isle of Wight is a statutory requirement. The PCT currently provides some services for the island (e.g. district nursing, podiatry, health promotion, dental services and GP out of hours services). If the intention is to completely separate provision from commissioning of services, the PCT could cease to provide services itself and instead commission these services from the Trust.

125 The PCT could continue to carry out its functions (including commissioning health services) for the Isle of Wight on an independent basis.

126 If the intention is to integrate the commissioning of health, social care and housing, the Section 31 powers must be used. These powers would allow the PCT to exercise the Council's social services and housing commissioning functions in conjunction with its own NHS commissioning functions. A Section 31 agreement documenting the integration arrangements would be required.

127 The Council and PCT could either:

- (a) at the same time as, and as part of the process of, integrating their commissioning functions; or
- (b) once their commissioning functions have been integrated;

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<sup>5</sup> Section 16A (1A) of the NHS Act 1977.

consider moving to Care Trust status based on the PCT Care Trust model. This would then create a single organisation for the Isle of Wight which was responsible for the commissioning of NHS, social care and housing services.

### **Establishing a single organisation to provide health, social care and housing services**

128 In order to integrate the provision of health, social care and housing services, the Section 31 powers must be used. These powers would allow the Trust to exercise the Council's social services and housing provider functions in conjunction with its own NHS provider functions. A Section 31 agreement documenting the integration arrangements would be required.

129 The Council and Trust could either:

- (a) at the same time as, and as part of the process of, integrating their provider functions; or
- (b) once their provider functions have been integrated;

consider moving to Care Trust status based on the NHS Trust Care Trust model. This would then create a single organisation on the Isle of Wight responsible for the **provision** of NHS, social care and housing services.

### **Could two care trusts be established (one for commissioning and one for provision)?**

130 If the Care Trust route is taken for both commissioning and provision of health, social care and housing services, the result would be two Care Trusts on the island, one responsible for commissioning NHS, social care and housing services and the other responsible for service provision. Whilst it would be unusual to have two Care Trusts (one responsible for commissioning and one responsible for provision) and this approach has not, to date, been adopted elsewhere, it is certainly feasible. Furthermore, two Section 31 schemes in the same area, one covering commissioning and the other provision, is quite a common approach. The Care Trust route merely takes this one stage further.

### **Local Authority Scrutiny**

131 The scrutiny arrangements would need to reflect the structure finally adopted. The scrutiny role is likely to be broadly the same after the organisational reconfiguration as before. It would be important, however, to minimise any overlap between the role of the scrutiny committee and the role of the governance arrangements applicable to the new organisational structure (once decided).

## **OBSTACLES TO INTEGRATION AND MOVING FORWARD WITH THE 2 SHORTLISTED OPTIONS**

### **Prescribed functions**

132 The Section 31 powers can only be used in respect of **prescribed** NHS functions and **prescribed** local authority "health related" functions. These prescribed functions are set out in the Partnership Regulations.

## Prescribed NHS Functions

133 The prescribed NHS functions<sup>6</sup> include: providing or securing most hospital and community health services (including rehabilitation); medical and dental inspection for school age children and after care and supervised aftercare under the Mental Health Act 1983.

**134 There are notable exclusions, however, namely: surgery, radiotherapy, termination of pregnancies, endoscopies, the use of Class 4 laser treatment and other invasive treatments, and emergency ambulance services. In addition, family health services (e.g. GP/general medical services, personal medical services, dental services, ophthalmic services, pharmacy services) are not covered.**

## Prescribed local authority “health related” functions

135 The relevant prescribed local authority “health related” functions<sup>7</sup> include:

- most social services functions (subject to some exceptions – see below); and
- specified housing functions:
  - relating to allocation of housing and homelessness - under Parts VI and VII of the Housing Act 1996; and
  - grant making powers - under the Housing Grants, Construction and Regeneration Act 1996.

136 The principle exclusions in respect of social services functions relate to **the appointment of Approved Social Workers and the power to enter and search premises** under Sections 114 and 115 of the Mental Health Act 1983 respectively.

## How might the limitations imposed by the prescribed functions be overcome?

137 The exclusions from the list of prescribed NHS functions are particularly problematical for the Isle of Wight. A significant element of the services currently provided by the Trust do not fall within the scope of the prescribed NHS functions for the purpose of the Section 31 powers (e.g. surgery, emergency ambulance services etc). In addition, if the PCT commissions the Trust to provide family health services (e.g. GP out of hours and dental services) these will also be outside the scope of the Section 31 powers. The same position would apply to functions exercised by the PCT relating to commissioning family health services and other FHS related functions.

138 This problem could be dealt with in one of two ways:

- (a) by keeping the excluded NHS functions outside of the Section 31 integration arrangements (i.e. outside of the Section 31 agreement). This would need to be reflected both in the financial and governance arrangements of the Section 31 agreement to ensure that the position was completely clear; or

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<sup>6</sup> Full details are contained in Regulation 5 of the Partnership Regulations

<sup>7</sup> Full details are contained in Regulation 6 of the Partnership Regulations

- (b) by highlighting the problem, and the Isle of Wight's unique position, with the Department of Health and lobbying for an amendment to the Partnership Regulations.

## PROCESS AND TIMESCALES

### Step 1 – Trust merger with the PCT

#### Option 5

- 139 The merger of the Trust with the PCT and the subsequent dissolution of the Trust would require the consent of the Secretary of State. Consultation on the dissolution of the Trust would be required.<sup>8</sup> Additional consultation with Trust staff would be required as they are likely to transfer to the PCT under the Transfer of Undertakings (Protection of Employment) Regulations 1981 (as amended) ("TUPE").

Orders would then be prepared dealing with staff and property transfers and the dissolution of the Trust.

### Stage 2 – Integration between PCT and Council

- 140 As discussed above, the PCT could integrate commissioning and provision of services with the Council either in advance of moving to Care Trust status or at the same time as being established as a Care Trust. In both cases the Section 31 agreement would need to be developed and agreed before the integration could "go live".

- 141 Application for Care Trust status is governed by Regulations.<sup>9</sup> The Department of Health has also issued guidance on the application process.<sup>10</sup> Briefly, the process should be as follows (those steps specifically required under the Regulations are shown in bold):

1. The parties complete a self audit tool to assess their readiness to move to Care Trust status;
2. The PCT discusses proposals with Strategic Health Authority to ensure consistency with the strategic needs and plans of the region;
3. The Council notifies the Commission for Social Care Inspection who notify the Health and Social Care Change Agent Team;
4. Informal consultation with those likely to be affected by the application for Care Trust status is carried out;
5. The Care Trust Board appointment process begins – to identify chair and lay members of the Board;
6. The parties prepare consultation documentation and agree the style of consultation;
- 7. Formal consultation with such persons as appear to ... be affected by the application for Care Trust status is carried out.** The Regulations do not specify the

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<sup>8</sup> In accordance with the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 1996.

<sup>9</sup> The Care Trusts (Application and Consultation) Regulations 2001

<sup>10</sup> Care Trust Application, Consultation, Assessment and Establishment Processes

time which should be allowed for consultation. However, the DoH guidance states that the consultation period needs to be a reasonable amount of time within which stakeholders affected by the proposal can consider and respond to it in a meaningful way. A period of at least 3 months is recommended. Consultation is also a requirement under TUPE in relation to any staff that may be transferring to the Care Trust (e.g. the Council social services and housing staff). Again, the TUPE Regulations do not specify the period of consultation, the requirement is simply that the time allowed is reasonable.

8. Following the consultation period a formal written application for designation as a Care Trust is made. As part of the application, a copy of the proposed or existing Section 31 agreement between the PCT and Council must be supplied. (This depends on whether integration between the PCT and Council, using the Section 31 powers, has occurred prior to the application for Care Trust status or is to take place at the same time).

9. The application is considered jointly by the Strategic Health Authority and the Commission for Social Care Inspection who will then prepare a joint report (the guidance indicates this should be prepared within 14 days) for submission to the Secretary of State making recommendations, with reasons, for the granting or otherwise of the application. Prior to the receipt of the written application, the Strategic Health Authority and Commission for Social Care Inspection will have been assessing the proposals on an on-going basis starting with the informal consultation period. The assessment of the application is measured against standard assessment criteria.

10. Policy officers will initially review the SHA/CSCI joint report and provide comments (within 14 days). These comments are then incorporated into the report (within 7 days) and the report submitted to the Secretary of State.

11. The Secretary of State will then either:

- Approve the application; or
- Approve the application with qualification (and providing reasons for the qualification); or
- Reject the application (with reasons).

12. Following approval or qualified approval, the amendment of the PCT's existing establishment order is prepared for signature by the Secretary of State. Once signed by the Secretary of State the order is laid before parliament for 10 days before coming into force. This completes the process and gives the Care Trust legal status.

13. Finally, the Care Trust Board appointment process is completed.

142 It would be possible for Stages 1 and 2 (described above) to take place at the same time. However, as a single step this would represent a significant organisational change and a staged approach may therefore be preferable.

## **Process for establishing a separate commissioning body**

### Option 6

- 143 If the PCT is to commission the services it currently provides from the Trust, then as a matter of good practice, consultation on this change in service provision should be undertaken.
- 144 If a decision to merge with another PCT on the mainland were made, the merger and subsequent dissolution of one of the PCTs would require the consent of the Secretary of State. Consultation on the dissolution of the relevant PCT would also be required.<sup>11</sup> Additional consultation with staff would be necessary as they are likely to transfer to the new merged PCT under TUPE. Orders would then be prepared dealing with staff and property transfers and the dissolution of one of the two merged PCTs.
- 145 If the intention was then for the PCT (or merged PCT) to integrate commissioning of services with the Council this could either occur in advance of a possible move to Care Trust status or at the same time as being established as a Care Trust. In both cases, or if the parties decided to simply integrate without moving to Care Trust status, a Section 31 agreement would need to be developed and agreed before the integration could “go live”.
- 146 If Care Trust status was the objective then the procedure in paragraph 142 would apply.
- 147 If the parties decided against moving to Care Trust status, consultation on the use of the Section 31 powers, including consultation with any staff affected (e.g. where Council staff may transfer to the PCT under TUPE) must have occurred before the integration arrangements could take effect.

## **Process for establishing a single entity for the provision of services**

- 148 Similar principles apply as for establishing a separate commissioning entity (see paragraphs 145 to 147 above). For the sake of completeness these principles are repeated below.
- 149 The Trust could integrate the provision of services with the Council either in advance of moving to Care Trust status or at the same time as being established as a Care Trust. In both cases, or if the parties decided to simply integrate without moving to Care Trust status, a Section 31 agreement would need to be developed and agreed before the integration could “go live”.
- 150 If Care Trust status was the objective then the procedure in paragraph 142 would apply.
- 151 If the parties decided against moving to Care Trust status, consultation on the use of the Section 31 powers, including consultation with any staff affected (e.g. where Council staff may transfer to the Trust under TUPE) must have occurred before the integration arrangements could take effect.

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<sup>11</sup> In accordance with the [National Health Service Trusts \(Consultation on Establishment and Dissolution\) Regulations 1996](#).

### **Sequence of events**

152 The steps relating to the establishment of a separate, integrated commissioning body could take place at the same time as the steps relating to the establishment of a single, integrated, service provider. Alternatively, they could take place sequentially or on a phased basis.

### **Conclusion**

153 This sets out the broad legal principles applicable to the proposed organisational reconfiguration of health, social services and housing on the Isle of Wight. It is not intended to cover matters of finer detail although the finer detail will need to be worked through. If the parties intend to proceed with the reorganisation, using the Section 31 powers, with a view to the possibility of progressing to one or more Care Trusts, then we would recommend an early meeting with your chosen legal partner to work through the issues involved and consider some of the finer detail.

# Integration of Children's Services

## Introduction

154 The approach that we adopted to address this involved two key elements:

- critical review of the Island's '*Local Preventative Strategy*', based on our knowledge of the national policy agenda and key developments and best practice in other geographical areas
- consultation with the key stakeholders for Children's services on the Island (represented by the CHYPS group), in order to determine the range of views on the preferred future strategy; and the extent of current planning and structures to implement this in practice

155 This section of the report therefore outlines the key findings derived from this work, and includes recommendations on the practical first steps that the Island needs to take in order to achieve a coherent future strategy and implementation process for Children's services; that is aligned to both:

- The national policy agenda for Children's services
- The preferred options for the wider configuration of Health and Social Care services on the Island

## The National Policy Context

156 The integration of children's services is a key policy initiative that includes a broad range of stakeholders and interests. A number of models of integration have arisen. Principal among these are:

- \* Sure Start
- \* Youth Offending Teams (YOTs)
- \* The Children's National Services Framework
- \* The Connexions service
- \* Tomorrow's Children
- \* The development of Children's Trusts Pathfinder models
- \* The Green Paper Every Child Matters

## Children's Trusts

157 Children's Trusts have two clear development strands: those set out in the Government's Green Paper *Every Child Matters*, (this has been augmented by the "Children's Bill (2004)" and "Every Child Matters: Next Steps") and a variety of pathfinder Children's Trusts.

- 158 The Bill does not create Children's Trusts as statutory organisations but 'encourages' and facilitates their development. Statutory guidance, expected in the autumn, will make it clear that for the Local Authority, PCT and Connexions local co-operation will include 'consideration' of joint commissioning and that this could extend to the acute trusts, YOT and voluntary sector as appropriate locally. There is a new enabling power for partners to pass budgets and resources "enabling broader pooling arrangements that S31 of the Health Act 1999 – this underpins existing trusts.
- 159 It is also clear that a Children's Trust will be based in local government but 'engage' a wide range of partners and may also commission services on behalf of the Local Safeguarding Children Board which will replace the ACPC.
- 160 As a guide to management arrangements, it is envisaged in 'Next Steps' that Children's Trusts will typically sit at the upper tier level "but may want to tailor their structures to local circumstances

### **Director of Children's Services**

- 161 Overlaying the development of the Children's Trusts' Pathfinders, the DfES Green Paper *Every Child Matters* requires local authorities to create the new statutory post of Director of Children's Services – "key services for children should be integrated within a single organisational focus (nationally and locally). This, the creation of a lead council member for children's services and the post of Minister for Children point to further, longer-term integration.
- 162 Services managed by the Director of Children's Services (accountable to the lead member) will themselves be integrated with Children's Trusts. "These bring together local authority educational children's social services, some children's health services, Connexions, and can include other services such as Youth Offending Teams.
- 163 "Children's Trusts will normally be part of the local authority and will report to local members." The spine of accountability is deemed to spread from the Trust Director through the Director of Children's Services to the Chief Executive. The Green Paper will also "require local authorities to work closely with public, private and voluntary organisations to improve outcomes for children."
- 164 One option that the Island may wish to consider is to establish a local Children's Commissioner. Most Local Authorities that have embarked upon integration prior to the "Bill" have done so, usually on a joint funded basis.

### **The position on the Island**

- 165 In response to the national policy context outlined above, the agencies responsible for Children's services on the Island have taken the following steps:
- Developed a 'Local Preventative Strategy' for 2004/5, outlining plans to integrate services through the establishment of a Children's Trust
  - The Local Authority have appointed a Director of Children's services (from 1<sup>st</sup> April 2004), with plans to locate responsibility for all Local Authority Children's services within the Education division from October 2004

This broad approach clearly fits within the scope of the national policy direction, especially given the flexibility that currently exists to fit arrangements to local circumstances and needs.

### **Integration of Children's Services on the Island**

166 During the course of our work, the Children's Services stakeholder group demonstrated a strong, unanimous desire to pursue the integration of Children's services on the Island. The group is very keen that integrated Children's services should not stand alone or be independent from the envisaged Health and Social Care Trust for the Island from April 2006. While this would certainly appear possible within the scope of the current guidance, specific advice on the acceptability and process for achieving this would need to be sought. Further guidance on the process for establishing Children's Trusts is due to be issued by the DfES in 2004/2005.

### **Planning the integration**

167 There are important issues that need to be taken into account when considering the planning of integrating services:

- As far as possible, artificial or unnecessary organisational barriers to joint working in Children's services should be avoided
- Affordability and the ability to exploit economies of scale should be considered, thereby questioning the desirability of creating a Children's Trust as a separate organisation from the envisaged Health and Social Care Trust for the Island
- The LPS pre-dated the Children's Bill, and was written with a vision of a Children's Trust that incorporated a Commissioning function
- Need to focus on strategy first, rather than structure. The latter should be determined by the needs of the former.
- The current policy position represents a valuable opportunity to 'unite' Children's services on the Island; and concerns over structure should not be allowed to impede this and the potential it offers to develop multi-agency working
- If Children's services are integrated within a wider Health and Social Care trust, it will be necessary to ensure that resources are not diverted away from Children's services to other areas of acute provision with significant financial pressures
- Similarly, within a Children's Trust, processes must be in place to ensure that acute services do not dominate to the detriment of Social Care services for Children and Young people
- The resource issue and ensuring that acute provision does not direct resources from children's services especially preventative functions
- The issue of governance and how we construct trust arrangements that accommodate the statutory requirements of Local Authorities with regard to Children's Services
- The need to consider the proposed joint inspection proposals for Children's Services and how these would be accommodated.

## **The extent of service integration**

- 168 Our work in this area has revealed a high degree of consensus (across the full spectrum of stakeholders - Healthcare Trust, PCT, Social Services and Education) on the preferred format for a Children's Trust. There is also unanimity in the wish to develop the inclusive model set out in the LPS. Again, this model fits within the (flexible) scope of services provided in the current guidance and the Pathfinder Trusts.
- 169 This model incorporates the full spectrum of health, education and social care services relating to Children and Young People. In essence, it is felt that a Children's Trust should represent all services from 'conception to 18' (plus, those services which Social Services are responsible to provide for 18 – 24 year olds, for instance to Care leavers). However, it is essential to recognise that, pragmatically, there will be some services 'on the margins' that it may not in reality be possible to actually include within the Children's Trust. For these services, it will be essential for those responsible for commissioning Children's services to ensure that robust Service Level Agreements are in place.
- 170 There is also strong support for developing a network of 'virtual' teams (as set out in the LPS) as part of a phased approach to integrating the complex network of health, education and social care services for children. The structure and nature of these virtual teams is an area requiring further detailed planning and planning; to ensure that they are consistent with the geographical and service needs of the island.

## **Timetable for integration**

- 171 The high degree of stakeholder agreement and clarity is a significant positive step for the Island. However, at present there is no process in place to convert this vision into reality. That is to say, there are currently no strategic or implementation plans.
- 172 The LPS, while a valuable document, lacks the following key elements to be a truly effective tool:
- Full representation of, and ownership by, the health sector (PCT and Healthcare Trust)
  - A detailed project plan
  - Outline of a clear project management structure
- 173 In order to address this, it is strongly recommended that the island considers the following steps in order to take forward the integration of the Island's Children's services:
- Appointment of a Project Board to direct the integration of Children's Services. This Board should encompass senior representation from each of the three principal service areas: Health (PCT and Trust), Education and Social Services: August 2004.
  - Project Board to appoint a Project Manager to drive the day to day progress of the integration project: September 2004.
  - Project Manager, with oversight from the Project Board and in consultation with the relevant stakeholders, to produce a detailed Project Plan to achieve the integration of Children's services (in a Children's Trust or other named body within the Local Authority) from April 2006. The project plan must include key milestones (as set out in the LPS), but also the detailed steps and actions required

## Impact of integration

- 174 Clearly the timing of when integration takes place needs to be considered alongside a number of other factors, including project management capacity, establishing governance arrangements and, importantly the impact integration will have on the Council.
- 175 Having considered the implications on the Council if integration of Children's Services took place at the same time as the formation of a Health & Social Care Trust (HSCT), it has been decided following consultation with the steering group on 22 June that April 2006 is unrealistic, because
- The new guidance on Children's Trusts will be provided later this year and will require further discussion with DfES, DoH and ODPM in the context of this innovative approach.
  - Of the impact on the council's viability and political position through the loss of its two largest service areas namely Social Services and Education.
  - How members will conduct their corporate parenting responsibility if the service transferred to HSCT.
- 176 This may well impact on the timetable for the development of a Health & Social Care Trust by April 2006. The above issues need to be resolved for Children's Services to become a part of the new organisation. The main focus should be the development of a Children's Trust as part of the Local Authority by April 2006 and integration into the new organisation should follow this at an agreed point in time. By this time there will be greater clarity in the governance and reporting arrangements for Children's Trusts.

## Key steps

- 177 In order to provide an indication of the transition process we have produced an outline of the key steps, with target dates, on page 45. These steps will provide the means by which to develop integrated Children's services for the Island from April 2006.
- 178 The Island possesses a significant advantage in the high level of consensus that exists concerning the desirability and preferred structure of integrated Children's services. In order to harness this and exploit the potential that it offers, the Island should afford close consideration to the following steps:
- Put in place the project management arrangements outlined above to work towards the creation of a Children's Trust in the Local Authority by April 2006. Consideration should be given to the establishment of a shadow Children's Trust in 2005
  - As part of this, produce a project plan that outlines the detailed actions required to achieve this
  - Alongside this, and dependent on developments at the wider Island level, work towards the objective of the Children's Trust becoming an integral part of any Health and Social Care Trust formed for the Island as a whole, from the earliest possible date beyond April 2006
  - The constitution and governance of both the Children's Trust and the Health and Social Care Trust should be such that Children's services in general (and Children's Social Care services in particular) are 'protected' in terms of income and service development from the (financial) pressures faced by other services.

- An effective communication strategy for all staff affected by both the creation of a Children's Trust and any subsequent alignment with a Health and Social Care Trust for the Island

# Organisational transition

## Introduction

179 We have mapped out in Tables 1 and 2 indicative transition plans for Option 5, Option 6 and the integration of Children's Services.

180 The following need to be considered in more detail:

- The transition process needs to be funded and have dedicated support. A change programme such as this cannot succeed without having dedicated project management.
- It will require effective co-ordination of actions across all key stakeholders, while ensuring that existing operations continue unaffected.

For the changes to have maximum impact, they need to be implemented as soon as possible, recognising legal and recruitment timescales.

## Outline Transition Plan

181 The outline transition plans shown overleaf, are presented not as recommended plans, but rather as an initial framework for discussion that would need to be developed and changed by key stakeholders. They are not exhaustive but provide an outline of the key milestones that could be applicable for either option. It demonstrates the magnitude of the task ahead.

182 Table 1 describes the indicative process for both Options 5 & 6, and Table 2 shows the process for the integration of children's services.

Workstreams	2004						2005						2006										
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mch	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mch	Apr	
<b>Management arrangements</b>			Commence internal recruitment process for single CEO for health	Configure executive management team to include DSS&H as co-opted Exec	Agree terms of reference and establish TSG			Begin recruitment process for the Care Trust Board				Shadow Care Trust Board in place (approximate)											Care Trust Board in place
<b>Org vision</b>							Implications of organisational vision assessed		Org vision defined in outline			Outline org vision communicated to employees and organisational vision defined in details											HSCT established
<b>Delivery strategies &amp; plans</b>							Implications of delivery strategies assessed		Delivery strategies defined in detail			Operational plans defined in outline		Development of 3-year HSCT activity & resource plan					3-year plan and 1st year budget approved				Delivery of plans & budgets commenced
<b>Org Structure</b>							Implications of proposed new org(s) and service configuration assessed		Outline org structure defined		Outline service configuration defined		Detailed org and service structures defined										HSCT organisation operational
<b>People management</b>							Current T&Cs assessed		Principles for future T&Cs defined						Proposals for new T&Cs defined and policies and procedures developed								Future T&Cs approved and implemented
<b>Programme and project management</b>							Programme & project definition documents produced and approved																
<b>Consultation (*engagement with unions)</b>		Consultation on preferred option					Informal consultation with effected parties on application process				Formal consultation on application with effected parties including staff												Consult on the T&Cs
<b>Communication</b>	Take PwC report to respective org boards	Develop a communication strategy											T&Cs principles communicated to employees										Roadshows on the org vision Communicate policies & procedures
<b>Application process</b>						Complete self audit tool	Agree strategic fit with SHA and Council inform CSCI	Appoint Chair and Lay Members and begin recruitment process for the Care Trust Board	Prepare consultation documents				Write application for Care Trust	(Consideration of application by SHA, CSCI, Secretary of State)									
<b>Setting up of separate commissioning body (option 6)</b>									Org vision defined in outline		Commissioning strategy defined				Recruitment of Care Trust Board								Commissioning Care Trust established
									Outline org structure defined						Roadshows on the org vision								

Table 1: Indicative Transition plan for option 5 and 6

Workstream	2004						2005												2006				
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mch	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mch	Apr	
<b>Management arrangements</b>		Agree terms of reference and establish Project Board																Recruitment of Children's Management Team					
<b>Org vision</b>							Implications of organisational vision assessed			Org vision defined in outline			Outline org vision communicated to employees and organisational vision defined in details									Children's Trust established	
<b>Delivery strategies &amp; plans</b>							Implications of delivery strategies assessed			Delivery strategies defined in detail			Operational plans defined in outline			Development of 3-year Children's Trust activity & resource plan		3-year plan and 1st year budget approved		Delivery of plans & budgets commenced			
<b>Org Structure</b>				LA transfer Children's Social Care to Education Dept.			Implications of proposed new org(s) and service configuration assessed			Outline org structure defined		Outline service configuration defined		Detailed org and service structures defined								Children's Trust organisation operational	
<b>People management</b>							Current T&Cs assessed			Principles for future T&Cs defined						Proposals for new T&Cs defined and policies and procedures developed			Future T&Cs approved and implemented				
<b>Programme and project management</b>			Appoint Project Manager		PB and PM develop an agreed Project Plan		Programme & project definition documents produced and approved																
<b>Consultation (*engagement with unions)</b>							Informal consultation with effected parties			Formal consultation on application with effected parties									Consult on the T&Cs				
<b>Communication</b>	Take PwC to respective org boards	Develop a communication strategy										T&Cs principles communicated to employees									Roadshows on the org vision		
<b>Application process</b>	Application process for Children's Trusts not yet formulated by DfES. However, as this advice is released, the IOW will need to pursue this according to the overall timescale of creating a Children's Trust in April 2006												Application process should be underway										
<b>Link to HSCT</b>																						Children's Trust established. Begin work on developing integration with HSCT for the Island	

**Table 2: Indicative Transition plan for integration of children's services**

# Supporting commentary for indicative transition plans for option 5 & 6

## Management arrangements – Phase 1

- i) This maps out the establishment of a single management team at the earliest opportunity, as long as it is achieved within existing legal regulations. An appointment of a CEO to provide leadership for the two legal entities of the PCT and Healthcare Trust for an interim period is recommended.
- ii) Shortly after the appointment of a CEO, the executive director posts that can be common to both the PCT and Healthcare Trust, subject to further legal clarification, will need to be appointed in accordance with existing legislation and governance frameworks.

## Management of Care Trust – Phase 2

- i) A formal process of appointing the Care Trust Board will commence, likely to be 12 months later, with the appointment of the Trust Chairman, and then subsequently the Chief Executive and Senior Management team
- ii) Appendix 5 lists the appointment process for a Care Trust Board. Some of the terminology in the document is now a little out of date as it was produced in 2002 in advance of the first Care Trusts being established. For example, for Regional Office read Strategic Health Authority and Social Care Inspectorate read Commission for Social Care Inspection.

## Transition Steering Group

- iii) The new CEO, in partnership with the IOW Council and the PCT, should establish a Transition Steering Group (TSG) to oversee the transition from where they are now to a new organisation in the future.
- iv) The TSG would provide a framework for the transformation of the Island's current organisational structure to the agreed final state and would probably include executive and non-executive director representatives from the PCT and Healthcare Trust, members from the IOW Council and representation from the SHA. It will also be a pre-requisite that this process of transition will require dedicated project management.

## Organisational Vision

- v) The vision for the new organisation needs to be defined and articulated. This is an area of work that could be facilitated by the TSG.
- vi) Communicate the vision with employees in order to familiarise and achieve commitment.

## Delivering strategies & plans

- vii) Mapping existing plans relating to strategic development work across health organisations and social care/housing is required.

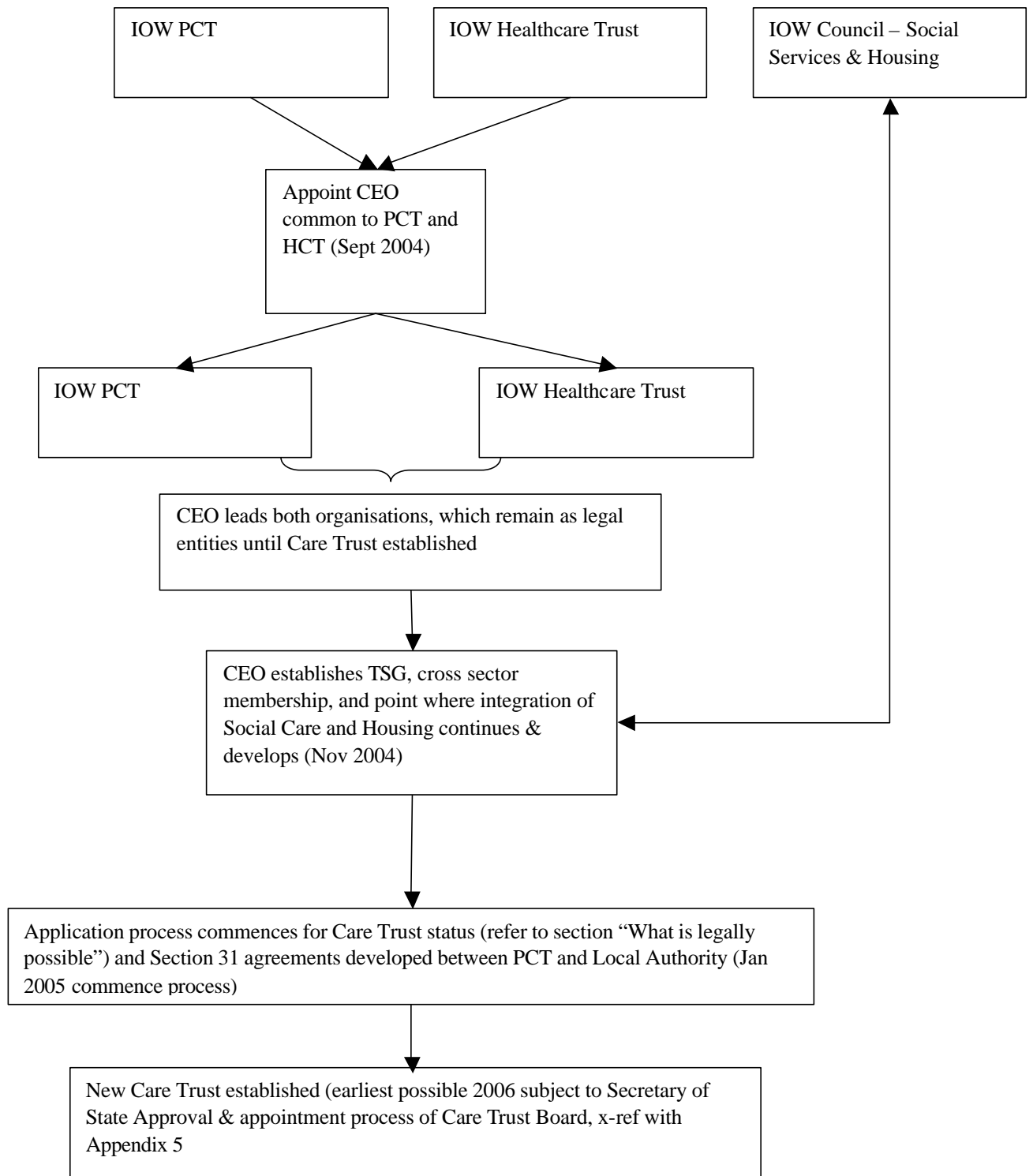
- viii) Common and inter-sector issues, goals and challenges, all need to be determined beforehand.
- ix) Joint planning across sectors is necessary to achieve a balance with existing commitments, and to establish a new way of commissioning.

**People management (policy, procedures and transition)**

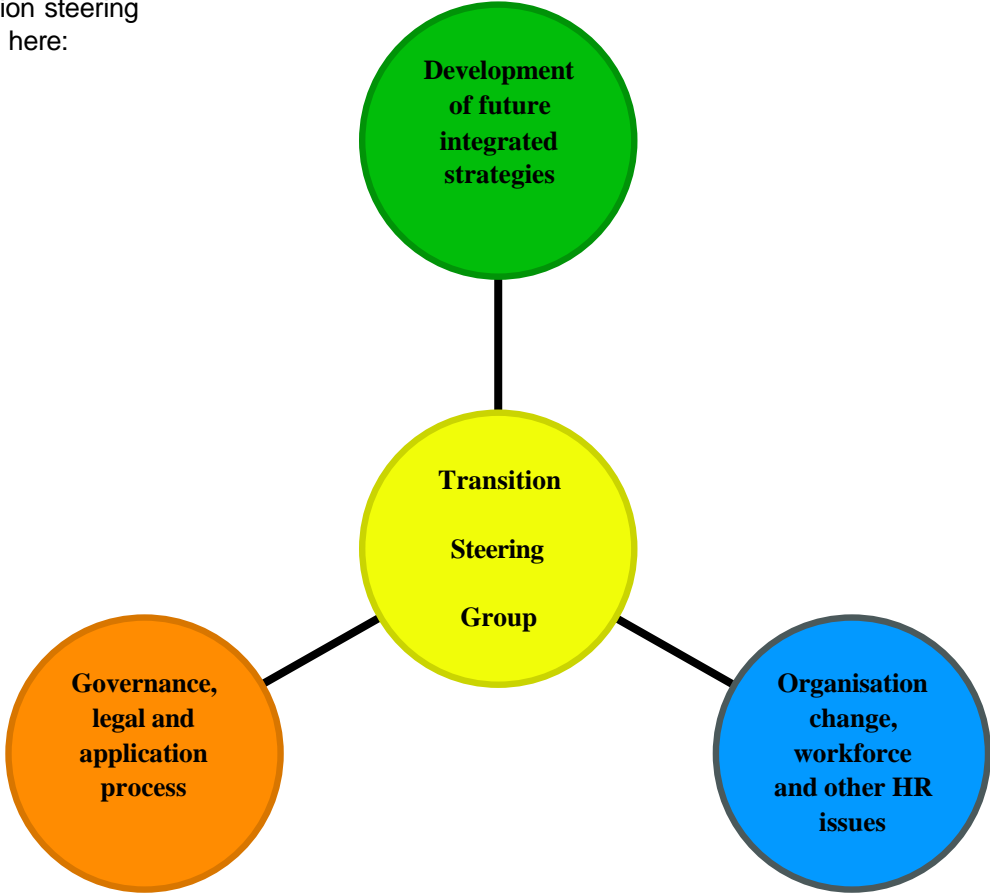
- x) Assess and define TUPE issues at an early stage.
- xi) Use opportunity to decide on what is required for the future – don't just stick to what you have now
- xii) Look at external pressures i.e. Agenda for Change, Working Time Directives, National Service Frameworks
- xiii) Need to develop consultation procedures/arrangements with staff/ trade union sides
- xiv) Staff need some idea of what's happening to work out/ anticipate own position before this

An outline framework for a co-ordinated approach to transition is described overleaf. It is not exhaustive, and describes the work streams that the new management team should consider as part of a whole system process of transition.

A high level schematic of the transition process is described below



An example of what the transition steering group could consider is shown here:



# Shared Services

- 183 During the course of our work we have identified that there are likely to be opportunities for maximising the potential of sharing services particularly those of a corporate nature (i.e. Finance, HR, IT, Estates Management, Occupational Health etc).
- 184 We identified the existing arrangements for sharing of services and it is clear from this that the majority are provided by the Health Care Trust for the PCT and the Corporate Services Department for the Social Services & Housing Department of the IOW Council.
- 185 There appears to be limited use of mainland services in the provision of corporate type functions and we believe that the potential for testing for value for money needs to be explored further.
- 186 Our experience elsewhere suggests that when three or four organisations merge into one, savings in the region of 5-10% could be possible. Clearly these are indicative levels and will differ depending upon local circumstances. Our conclusion from this is that a detailed study on the value for money of existing shared services across the three organisations is conducted with a view to develop a shared services “agency” function that could service all three organisations on the Island.

# Conclusions and way forward

- 187 We recommend that the Steering Group should pursue Option 5 or Option 6.
- 188 It was agreed by the Steering Group on 10 May that we would not identify a preference for either of the two options. It was felt that both options needed to be considered by each respective organisation in light of what we have reported, following which a decision would be made on which way to proceed and what further detailed work is required.
- 189 The decision to review the organisational configuration has been one of the catalysts for change. Stakeholders have suggested, quite forcibly at times, that the need for change is a necessity and that the status quo cannot continue. As we indicated in our interim report there were clear signs that relationships between organisations and the ability to turn joint commitment into reality need strengthening. Our view is that one way of achieving this early on is to integrate management teams where possible within existing legislation, hence our recommendation that this should happen as soon as possible.
- 190 In relation to the integration of children's services there is clear ambition to integrate fully into the new organisation. Whilst this is positive the timing of this transition and impact on the IOW Council needs to be carefully considered before any firm decision is made. Key stakeholders for Children's Services need to embark on further consultation with the IOW Council, PCT and Healthcare Trust to agree the steps required to achieve full integration of children's services.
- 191 In summary, we believe that both of the options that have been short-listed could achieve the Island's original purpose for commissioning this review – that being the reconfiguration of organisations to achieve the Isle of Wight Healthcare Strategy and to deliver safe, sustainable and affordable healthcare.

## Way forward

- 192 In determining the way forward the following recommendations are made:
- 192.1 The content of this report should be considered by each respective organisation in order to choose which option to pursue.
- 192.2 Once each organisation has considered this report, a formal period of consultation should commence.
- 192.3 Once a decision has been made in principle based on internal and external consultation, further detailed legal advice should be sought on the legal process to be followed.
- 192.4 Subject to remaining within current and future legal frameworks and NHS Regulations, the NHS in Hampshire & Isle of Wight should strongly consider the appointment of a single CEO and executive management team to provide leadership for the PCT and Healthcare Trust.
- 192.5 Once the CEO is appointed, a Transition Steering Group (TSG) needs to be established to direct and drive the change process.
- 192.6 Specific project management support for the TSG should be identified and appointed.

- 192.7 A Project Board should be established to direct the integration of children's services. This Board should encompass senior representation from each of the three principal service areas: Health (PCT and Trust), Education and Social Services.
- 192.8 The Project Board should appoint a Project Manager to drive the day to day progress of the integration project.
- 192.9 Project Manager with oversight from the Project Board and in consultation with the relevant stakeholders, to produce a detailed Project Plan to achieve the integration of Children's services (in a Children's Trust or other named body) by April 2006. The project plan must include key milestones (as set out in the LPS), but also the detailed steps and actions required.
- 192.10 A detailed study should be conducted to explore the development and use of shared service agencies that could support the IOW and to ensure that existing shared service arrangements are providing effective and efficient services.

# Appendix 1 Terms of reference

Terms of reference for this project are as follows:

- To develop options for future organisational configuration for the commissioning and provision of NHS/Social Services on the Isle of Wight.
- To identify current and emerging national models, consider their appropriateness for the Isle of Wight and test potential options with the local Hampshire and Isle of Wight Strategic Health Authority and Department of Health and Office of the Prime Minister as appropriate.
- To identify a preferred option and a timetable for implementation with critical path and corporate governance implications identified.
- To make recommendations on the development of integrated children's services for the Isle of Wight in terms of timetable, service content and links with other statutory NHS/Social Services organisations.
- To identify potential shared services and systems (from support services).

The remit is to consider the PCT and Trust as organisations in their totality and the Directorate of Social Services and Housing and the Directorate of Education and Community Development within the Isle of Wight Council (the latter in regard to consideration of a Children's Trust).

Please note the preferred option must meet the following criteria:

- (i) It must retain the base for commissioning and provision on the Isle of Wight.
- (ii) It must be consistent with, and assist in the development of, the Healthcare Strategy
- (iii) It must cost less than the current organisational configuration.

## Appendix 2 Steering Group membership

- Mr Mike Fisher, CEO Isle of Wight Council (Chair)
- Mr Graham Elderfield, CEO Isle of Wight Healthcare NHS Trust
- Mr David Crawley, CEO Isle of Wight PCT
- Mr Glen Garrod, Director of Social Services and Housing
- Mr Mark Price, Director of Strategy, Isle of Wight PCT/Healthcare NHS Trust
- Hampshire & Isle of Wight Strategic Health Authority representation
- PricewaterhouseCoopers representation

## Appendix 3 Meeting with Stakeholders

The following meetings have taken place between 26 April and 9 June 2004:

Isle of Wight Healthcare Trust Chairman and Non Executives

Isle of Wight Healthcare NHS Trust CEO

Isle of Wight Healthcare NHS Trust CEO & Executive team

Isle of Wight Healthcare NHS Trust Operational Managers group

Isle of Wight PCT Chairman and Non Executives

Isle of Wight PCT CEO

Isle of Wight PCT CEO & Executive team

Isle of Wight PCT/Healthcare Trust/Isle of Wight County Council Finance Directors/Head of Finance (joint meeting following separate telephone interviews)

Isle of Wight County Council CEO

Isle of Wight County Council Director of Social Services & Housing

Isle of Wight County Council Director of Children's Services

Isle of Wight County Council Informal Executive

Debra Gardiner, Labour Leader

Andy Sutton, Conservative Leader

Isle of Wight Professional Executive Committee

Isle of Wight Youth Council

Staff Side representatives

Andrew Turner, MP for Isle of Wight

## Appendix 4 Strengths and Weaknesses of each option

Option 1 – Do nothing regarding organisational reconfiguration

Strengths	Weaknesses
No change, so working in a stable environment	Doesn't meet the SHA agenda
Enables further development of an island-wide service strategy	Limited ability to meet the national agenda
Management focus can be devoted to service strategy rather than organisational configuration	Loss of opportunity around the national agenda in health and social care
Limited distraction from the delivery of the financial recovery plans	Diseconomies of scale continued
Maintains a focus on the island	Unlikely to contribute significantly to achieving the financial recovery and service strategy plans
Limits demands on management time and stress levels	Remain insular
Enable for healthcare trust to apply for foundation status	Restrictive of the choice agenda & inability to achieve targets
No change to executive management team	Maintains the entrenched views of all the organisations & no changes to executive management team

Option 2 - The Isle of Wight Healthcare Trust transfers all primary and community care services (including mental health) to the Isle of Wight Primary Care Trust, leaving a core service of acute focused provision including ambulance services.

Strengths	Weaknesses
Clarity of business and closer fit to the national policy and planning guidelines	It creates and questions the viability of the acute trust and questions the viability of a PCT provider arm
Enables the (former) healthcare trust to focus more closely on acute services	Greater focus by the PCT on provision rather than commissioning of services
Clarity on cost base	Cost shifting rather than cost solving
Maintains links between acute and ambulance services	The process of change is de-stabilising
Keeps services on the island	Continuation of two management teams – doesn't fit with the SHA agenda
A truer picture of performance will emerge	Doesn't fit the joint statement of intent?
Limited disruption to management time	Remain insular

Option 3 - The Isle of Wight PCT transfers all primary and community care services to the Isle of Wight Healthcare NHS Trust, leaving the PCT to focus on its commissioning function. (The PCT would continue to commission public health and GP services)

Strengths	Weaknesses
Limited disruption to management	Doesn't fit with the SHA agenda
Enables the PCT to focus on commissioning, so will be in a good position to commission what is best for the island	Focus of management time and development maybe restricted as focus is more heavily placed on acute services
Enables the healthcare trust to focus on all provision	Doesn't meet the statement of intent
Fits with national agenda in relation to commissioner/provider split	Not sustainable in the long term as it doesn't address underlying service issues
Sustainable in terms of structure for the provider in the short term	Remain insular

Option 4 - The management executive teams of the Isle of Wight Primary Care NHS Trust and Isle of Wight Healthcare Trust merge. This will retain two legal entities (the PCT and Healthcare Trust) until further changes are agreed

Strengths	Weaknesses
Meets SHA agenda	Ability of the executive management team to meet the demands of two Boards
Closer working between the healthcare trust and the PCT	Diseconomies of scale still remain
Financial savings in relation to management costs	Reduced management capacity
Will facilitate the movement towards the integration agenda	Reduction in staff morale due to option being imposed by the SHA
Could be an incremental option although not an end in itself	Remain insular
No disruption to services	Continued tension between Trust Boards
Maintains focus on the island	

Option 5 - Establish a health & social care trust on the Isle of Wight that includes commissioning functions.

Strengths	Weaknesses
Meets the integration agenda	Purchaser and provider in one organisation, which could result in ineffective commissioning, unless a strong commissioning function is developed
Enables care to be delivered by care pathways – e.g. facilitates chronic disease management	Ability to integrate services where organisations have different cultures
Meets the SHA agenda	Complex, diverse organisation to manage
Provides a basis from which to further integrate services	Impact on the other Council services could be detrimental. Will the Council be viable?
Improved seamlessness of care i.e. movement through organisations	Diseconomies of scale still remain
Assists in the development of 'cradle to grave' services	Remains insular
Reduced management costs	
Improved commissioning of services as commissioning and provider functions are within the one organisation, with the opportunity to put the user/carer at the centre of commissioning – improved patient centred care	
Maintains services on the island	
New service model as it incorporates housing	

Option 6 - Establish a health & social care trust on the Isle of Wight that does not include commissioning. This becomes a separate body that can either be Island or mainland based.

Strengths	Weaknesses
Meets the integration agenda, New service model as it incorporates housing	If the commissioning is taken off the island commissioning becomes more remote and may not meet the needs and aspirations of the island's population
Enables care to be delivered by care pathways – e.g. facilitates chronic disease management	Ability to integrate services where organisations have different cultures
Meets the SHA agenda	Potential for there to be increased, continued, tensions between the commissioners and providers
Improved seamlessness of care i.e. movement through organisations	Impact on the other Council services could be detrimental. Will the Council be viable
Assists in the development of 'cradle to grave' services, Provides a basis from which to further integrate services	Diseconomies of scale still remain
Reduced management costs	Establishment of a separate commissioning body is likely to increase costs
Greater focus on the commissioning and provision of services as they are in two separate organisations	

Option 7 - SHA as commissioner of services for the island's population. Establish a Commissioning organisation that is an "out-post" of the SHA, and as part of this the primary care functions transfer into one health service body on the Island

Strengths	Weaknesses
Improved strategic commissioning	Ability to integrate services where organisations have different cultures
Easier to implement the choice agenda	Commissioning function removed from the island thus creating a gap between commissioner and the island population
Reduction in the diseconomies of scale within health	Some diseconomies of scale still remain
Improved access to tertiary care across the SHA area	Negative political impact for the island
Greater commissioning power	Users and carers' voices may be lost
Improved provider working across the whole SHA	
All health services focused under one management team	
Fit with SHA agenda	
Reduced management costs	
Improved care pathways, to include tertiary care	

Option 8 - Establish one Public Service organisation on the Island that encompasses all public services on the Isle of Wight

Strengths	Weaknesses
Initiative model that may attract central funding to develop this approach	Ability to integrate services where organisations have different cultures is unlikely to lead to successful integration
Will maintain focus on service delivery on the island and will ensure that the island has a voice at regional government level	No service strategy in place to support the integration agenda
Will require an incremental approach that can build on an action research approach which will ensure buy in and reflection of progress to date	Will require significant political support from all organisation, not currently in place
Should ensure greater economies of scale for the island	Will require primary legislation
Greater opportunity for the island to control its own destiny	Will require an evolutionary approach and may not be sustainable against s backdrop of significant financial pressure
Improved democratic approach on the Island	Will not resolve the economy of scale issues

Option 9 -

Establish a joint commissioning body and develop clinical networks of care so that services are commissioned on a programmed basis. This could mean that service provision is provided from a mixture of Island only, mainland only and Island/mainland services, including the independent sector.

Strengths	Weaknesses
Service fit for purpose – service by service development	Ability to integrate services where organisations have different cultures
Incremental approach that can build on success at each stage	Diseconomies of scale will continue with particular reference to management arrangements. Service diseconomies may not disappear by combining some organisational services
Opportunity to reflect and develop an approach that suits local circumstances	Requirement to achieve financial savings in the short term will work against this option
Should develop service strategies that are based on best practice	May lead to more services being provided by from the mainland
Improve Chronic disease management and development of care pathways	Islands influence may diminish

# Appendix 5 Application process

This is a copy of the DoH advice on care trust application, consultation, assessment and establishment process. Some of the text used is dated but it outlines the process that will need to be considered and in particular the Board appointment process. No indication of timescale for this particular part of the process is given.

## **CARE TRUST APPLICATION, CONSULTATION, ASSESSMENT AND ESTABLISHMENT PROCESSES**

### **1 Introduction**

1.1. This guidance describes the application, consultation, assessment and establishment processes for Care Trusts.

1.2. The advent of Care Trusts, announced in the NHS Plan, gives the opportunity for the greater integration of local authority and NHS bodies in order that services to users, patients and carers may be delivered more effectively and appropriately. Care Trusts will not be formed to improve or resolve structural and operational relationships as ends in themselves, rather they will be formed when these changes in structure and operation will make a clearly identifiable improvement to service for users, patients and carers.

1.3. For many of those applying for Care Trust status this process will be a natural progression of the joint working, partnerships and integration, which they have developed over a long period. Even for these organisations, however, the movement toward and achievement of Care Trust status may expose differences, dissent and tensions not previously encountered. Resolving these will ensure that there is a robust partnership which can support the activities of the Care Trust.

1.4. It is intended that when an NHS body is undergoing a change in status at the same time as the proposed move to Care Trust status, such as a Trust merger, that the two processes will be integrated throughout into a single unified and complementary process, i.e. there will be a single application, consultation, assessment and establishment process.

1.5. The stages of the processes:

- Initial discussion between partners
- Board appointment process
- Informal consultation, preparation of proposal, preparation of the formal consultation document and formulation of the formal consultation process
- Formal consultation
- Preparation of application
- Assessment of application – the Social Services Inspectorate Performance
- Division and the Regional Office
- Assessment of application – centrally based officers
- Secretary of State's decision

- Establishment
- Board appointment process (continued)
- Preparatory period

are detailed below.

## **2 Initial discussions between partners**

2.1. During this stage partners agree that the establishment of a Care Trust may be an appropriate mechanism to carry out (some of) their functions, (partners are defined as those bodies proposing to incorporate functions into the proposed Care Trust, all other interested bodies are referred to as stakeholders). When the NHS Trust/PCT that would be re-designated as a Care Trust is yet to be formed, the Health Authority will be the partner on behalf of the emerging organisation and any preceding organisations.

2.2. The proposal will emerge from the partners' belief that formation of a Care Trust will resolve issues or problems in service planning and/or delivery. The issues/problems may have been identified by users, patients, carers, and staff or through the mechanisms which examine the needs of the local community such as the Local Strategic Partnership or Health Improvement and Modernisation Plan planning processes.

2.3. The self-audit tool, previously published by the Department of Health will assist in this decision-making process. The tool is intended to be used by partners to assess their readiness to move to Care Trust status and details those tasks that need to be carried out in preparation to the move to Care Trust status.

2.4. Once the decision is taken to consult by the partners about moving to Care Trust status the local authority (LA) partners will notify the Social Services Inspectorate Performance Division, who will in turn notify the Health and Social Care Change Agent Team.

2.5. Before moving to consultation NHS partners will discuss their intentions with Regional Offices to ensure that the proposal is complementary to the strategic needs and plans of the region.

## **3 Board appointment process**

3.1. As the NHS partners move to consultation, the Regional Office will inform the NHS Appointments Commission of the proposed move to Care Trust status, in order that the Commission can begin the recruitment of the Chair and lay members to be selected by the NHS Appointments Commission.

3.2. Local authority partners will at this stage begin the identification of their nominations to the Board.

3.3. It is expected that the Chair of the Board would be appointed, in principle, prior to the Care Trust being approved by Secretary of State.

## **4 Informal consultation, preparation of proposal, preparation of the formal consultation document and formulation of the formal consultation process**

4.1. During this stage the partners will develop the nature of the Care Trust that will be consulted on. It is expected that partners will informally consult as to the nature of the proposed Care Trust before finally agreeing the proposal to be consulted on, the consultation document and the style of consultation.

4.2. Following this, the formal consultation document and process will then be prepared.

4.3. Experience has shown that those organisations that have a high level of stakeholder involvement in their structuring are likely to provide responsive services. As the consultation document and the nature of the consultation on this document may well determine the outcome of the consultation it is essential that these are planned and prepared with a significant level of stakeholder involvement. The views of users, patients, carers and staff will be key to the development of the proposal and the consultation process.

## **5 Formal consultations**

5.1. The formal consultation period needs to be a reasonable amount of time within which stakeholders affected by the proposal can both consider and respond to it meaningfully. A period of three months is considered normal.

5.2. For those sites wishing to gain Care Trust status in April 2002 it is recognised that the timescale involved is challenging and for this reason these sites may choose to have a shorter formal consultation period than the norm as a mechanism to meet the timescale. When a shortened consultation period is taken partners should note that they may need to provide evidence that effective consultation was achieved. Evidence could include a significant level and/or period of informal, or related, stakeholder consultation prior to the formal consultation.

5.3. The consultation document should be accessible to all stakeholders and the consultation process will be carried out in a manner which enables stakeholders to consider and respond to the consultation fully and effectively.

5.4. Consultation will include the following stakeholders as a minimum:

- Local communities
- Users, patients and carers
- Any other local appropriate user, patient and carer representative organisations
- The Members of Parliament who serve users, patients and carers and/or the geographical area of the proposed Care Trust
- Any Community Health Councils which serve patients and/or the geographical area of the proposed Care Trust
- Other NHS and LA bodies serving the users, patients and carers and/or the geographical area of the proposed Care Trust
- Those who will be working for the Care Trust (whether employed directly or indirectly)
- Bodies representing staff (whether employed directly or indirectly) who would be working for the Care Trust
- Staff representatives, trades unions and professional bodies
- Local independent sector organisations
- All those bodies with which the partners have contracts, either to deliver health/social care services on behalf of, or who deliver health/social care services on behalf of one (or more) of the partners.

## **6 Preparation of application**

6.1. Within 14 days (this period may be extended with the approval of the Social Services Inspectorate Performance Division and the Regional Office) of the end of the consultation period, the partners will prepare the application for Care Trust status and forward it to the Social Services Inspectorate Performance Division and the Regional Office. The application must include a response to the assessment criteria (attached at Appendix A).

6.2. The application will be based upon a self-assessment against the assessment criteria. It will include detail of the:

- Proposed name of the Care Trust
- Names and contact details of partners
- Geographical area to be served by the Care Trust
- Communities to be served by the Care Trust
- Services to be delivered by the Care Trust
- Proposed establishment and operational dates

6.3. The application, in principle, may be submitted for review before it has been formally adopted by the partners i.e. before Board or Committee approval. However the application must have full approval from all partners at the time that report is made to the Secretary to State as to the application.

## **7 Assessment of application by the Social Services Inspectorate Performance Division and the Regional Office**

7.1 The assessment will be an on-going process, beginning during the informal consultation period. The assessment will be a single integrated process carried out jointly by the Social Services Inspectorate Performance Division and the Regional Office. By reviewing the consultation's effectiveness and outcomes with the partners as it progresses, issues that the Social Services Inspectorate Performance Division and the Regional Office raise as to the process or the application may be managed in a pro-active and timely manner. The method of carrying out this assessment will be determined on a regional basis. Applications will be measured against the assessment criteria.

7.2 Within 14 days of receipt of the application from the partners, the Social Services Inspectorate Performance Division and the Regional Office will prepare a joint report for the Secretary of State. The report will give a recommendation, with reasoning, as to the granting, or otherwise, of the application.

## **8 Assessment of application – Centrally based officers**

8.1 For at least 2002/2003 all reports to the Secretary of State will be reviewed by policy officers with an interest in Care Trust policy, prior to their submission to the Secretary of State. This scrutiny will, amongst other things, allow policy officers to monitor the national development picture, the relevance of regulations and guidance and ensure national consistency in the development of Care Trusts.

8.2 Policy officers' comments, which will be incorporated into the Social Services Inspectorate Performance Division/Regional Office report to the Secretary of State, will be made within 14 days of the Social Services Inspectorate Performance Division/Regional Office completing their initial report. The Social Services Inspectorate Performance Division/Regional Office will incorporate these comments into the final report and submit it to the Secretary of State within seven days of their receipt.

## **9 Secretary of State's decision**

9.1 The Secretary of State may:

- Approve the application
- Approve the application with qualification
- Reject the application

9.2 If the Secretary of State approves an application with qualification, or refuses an application s/he will publish reasoning for this decision.

## **10 Establishment process**

10.1 On approval, or qualified approval, the Regional Office (in the case of a NHS Trust based Care Trust) or Primary Care Branch (in the case of a PCT based Care Trust) will notify the Chief Executives of all the partner agencies of the Secretary of State's approval.

10.2 The Regional Office will then prepare the information for inclusion in the establishment order. The Regional Office will also prepare any associated staff transfer, property and dissolution orders.

10.3 Using the information prepared by the Regional Office, Department of Health Solicitors will draft the Establishment Order (or, where appropriate, the amendment to the existing Establishment Order) for signature by the Secretary of State. Following signing the order will be laid before Parliament for 10 days before coming into force. The completion of this process will give the Care Trust legal status.

## **11 Board appointment process (continued)**

11.1 In the case of creating a completely new board the following will apply:

11.1.1 After the establishment order's enactment the expected Care Trust Chair will be notified by the NHS Appointments Commission of his/her formal appointment with effect from the establishment date of the Care Trust. A copy of this letter will be sent to the Chief Officers of all the partners.

11.1.2 Subsequently the Care Trust Chair (Designate) will be notified by letter by the Secretary of State, the letter will have been prepared by the Regional Office (in the case of a NHS Trust based Care Trust) or Primary Care Branch (in the case of a PCT based Care Trust). With the letter will be a copy of the establishment order, the corporate governance arrangements and notification of any special arrangements upon the Care Trust. The letter will also detail the establishment and operational dates of the Care Trust. This letter will be sent before the establishment date. A copy of this letter will be sent to the Chief Officers of all the partners.

11.1.3 The Care Trust Chair (Designate) would at this stage complete the recruitment of those lay members of the Board not nominated by the LA, in conjunction with the NHS Appointments Commission.

11.2 In the case of re-configuring an existing board the following will apply:

11.2.1 After the establishment order's enactment, the Care Trust Chair (Designate) will be notified by letter of such by the Secretary of State. The letter will have been prepared by the Regional Office (in the case of a NHS Trust based Care Trust) or Primary Care Branch (in the case of a PCT based Care Trust). With the letter will be a copy of the establishment order, the corporate governance arrangements and notification of any special arrangements upon the Care Trust. The letter will also detail the establishment and operational dates of the Care Trust. This letter will be sent before the establishment date. A copy of this letter will be sent to the Chief Officers of all the partners.

## **12 Preparatory processes**

12.1 It has been usual that newly formed NHS organisations have had a shadow/preparatory period between their establishment and operational dates. No such arrangement will be implemented for Care Trusts.

12.2 However, when one of the partners to the Care Trust is a NHS organisation moving to Care Trust status as it undergoes another change, i.e. two Trusts merging, a shadow/preparatory period will apply to this change, giving in effect a shadow/preparatory period for the Care Trust.

## **Appendix A – Assessment criteria**

These criteria are the minimum areas in which an application must show credibility. The application will need to show evidence as to how the criteria are/will be met (evidence of previous achievement by the partner organisations may be a valuable resource to cite). Success criteria and timescales will support all targets.

### **A1 Vision**

- A1.1. The vision for the Care Trust will include its short, medium and long term outcomes and deliverables.
- A1.2. Description of the additional outcomes and deliverables which establishing the Care Trust will bring to users, patients and carers compared to the existing arrangements.
- A1.3. Description of any other additional outcomes and deliverables which establishing a Care Trust will bring.
- A1.4. Description of those activities necessary to achieve the outcomes and deliverables, together with timescales.
- A1.5. The vision will detail how moving to Care Trust status is the most effective and appropriate mechanism for achieving the additional outcomes and deliverables.

### **A2 Standards**

- A2.1. Clear standards and targets to realise the vision.
- A2.2. Arrangements for maintaining and improving standards through the use of clinical governance and best value.
- A2.3. Arrangements to enable all staff (directly employed and otherwise) to be engaged in the delivery of quality services and the improvement of these services.

- A2.4. Robust information systems to support high quality clinical, other operational and management processes and monitor this activity.
- A2.5. Mechanisms to ensure that services meet national and local health and social care objectives.
- A2.6. Clear and effective risk assessment and management processes which ensure that the Care Trust, users, patients and carers, staff and all other individuals and organisations connected with the Care Trust are fully and appropriately protected.
- A2.7. An appropriate and effective complaints mechanism.

### **A3 Involvement with the community and other stakeholders**

- A3.1. The consultation process will have ensured that all partners and stakeholders were fully and appropriately enabled to be effective elements of the process and their contributions were given proper regard, weight and consideration.
- A3.2. The consultation will have shown broad local support for the proposed Care Trust.
- A3.3. The outcomes of the consultation will have been used appropriately in determining as to whether to progress to an application for Care Trust status or not.
- A3.4. The application will show evidence of meaningful knowledge and understanding of the needs of the local population and how the Care Trust would respond effectively to these needs.
- A3.5. The application will show that the Care Trust is able to engage with local communities and other stakeholders in planning and delivering its functions on an on-going basis.
- A3.6. Description as to how the Care Trust will recognise and meet the diversity of the communities it serves.
- A3.7. Effective and inclusive internal and external communications strategy.

### **A4 Corporate governance and organisational management**

- A4.1. An appropriate and agreed corporate governance arrangement. The board arrangements will provide for an appropriate mix of professional, management and leadership skills, partner representation and community knowledge. These arrangements will include measures to manage potential conflicts of interest.
- A4.2. Appropriate and effective organisational and service management arrangements.
- A4.3. A written agreement as to the functions delegated to the Care Trust, by the Local Authority. This agreement will detail the objectives, targets, standards, outcomes, financial and management arrangements and how they will be monitored. This agreement will include the dispute resolution mechanism.
- A4.4. Clarity of arrangements for working across organisational or geographical boundaries, including recharging, contracting, performance management and dispute resolution mechanisms.

## **A5 Human resources**

- A5.1. Clear arrangements for the transfer/secondment of staff to the Care Trust, which enjoy a significant degree of agreement with staff and their representative/professional organisations.
- A5.2. Arrangements for on-going high quality human resources management, including staff development.
- A5.3. Arrangements to ensure that the human resources function recognises and responds to the diversity of the communities/population that the Care Trust serves.

## **A6 Organisational development**

- A6.1. Description of the change process necessary to bring the Care Trust on-stream and description as to how service quality will be maintained during this period.
- A6.2. Analysis of the effects, positive and negative, of establishing the Care Trust on the local health and social care economy, including the economy's ability to meet local and national targets and objectives. Where negative impacts are identified proposals as to their mitigation and management should be described.
- A6.3. Sound arrangements for high quality organisational development.
- A6.4. Clarity as to the circumstances in which the Care Trust may be dissolved and an outline strategy for such dissolution.

## **A7 Finance/resources**

- A7.1. Transparent and agreed mechanism as to the budgets setting processes of the Care Trust, it will include the dispute resolution mechanism.
- A7.2. Arrangements for sound financial management and accountability, including arrangements for resolving any inherited budgetary issues.
- A7.3. Outline financial plan.
- A7.4. Clear strategy for the transfer (where appropriate) and on-going management of premises and other capital assets.
- A7.5. Plan as to the use of IT to support all aspects of the activity of the Care Trust.
- A7.6. Timetable as to the integration of the partners' IT systems.

**A8 Ability to deliver** (comment in this area is only required from the Social Services Inspectorate Performance Division and the Regional Office, applicants need only comment in this area if they so wish)

- A8.1. Analysis of the Care Trust's ability to deliver.
- A8.2. Analysis of the financial viability of the Care Trust.

## Appendix 6 Positive and negative views on existing structures

These were identified by staff groups that we interviewed during this review.

Positives	Negatives
<ul style="list-style-type: none"> <li>• Level of dedication</li> <li>• Strong development and support of staff</li> <li>• Good staff attitude surveys – good culture – nurtures and develops</li> <li>• Good engagement with GPs</li> <li>• Understanding of primary and secondary care</li> <li>• Good balance of primary, secondary and community care – good commissioner perspective</li> <li>• Joint working and joint appointments in some areas</li> <li>• All practices have same IT system</li> <li>• 1 PCT: 1 integrated: 1 LA</li> <li>• Captive audience, clear boundaries and public penetration (strong local press)</li> <li>• Strong information networks</li> <li>• strategies inclusive of all stakeholders</li> <li>• Common service direction</li> <li>• Integrated trust is ideal to support the transition of care for patients through the system; would be great if it included community services as well</li> <li>• Health continually takes the lead</li> </ul>	<ul style="list-style-type: none"> <li>• Concerns regarding the capacity of secondary care to respond to issues</li> <li>• Ability to deliver a growing agenda due to management capacity/unnecessary duplication</li> <li>• Too small a provider arm to be viable or to achieve targets and objectives – services in wrong place organisationally</li> <li>• Lack of community focus within organisations</li> <li>• More services need to be community/primary care focused – viability of acute services in combined trust – diseconomies of scale growing</li> <li>• Mechanisms needed to be put in place to meet national expectations and policies such as PBR</li> <li>• Which organisations are developing the partnerships, still a sense of different organisations doing different things?</li> <li>• Purchaser/provider split unhelpful, not fit for purpose</li> <li>• Polarised – need to manage vested interests</li> <li>• Very competitive – fighting for the same resource</li> <li>• Joint working – variable, based on personalities</li> </ul>

## Appendix 7 Barriers and levers to change

These were identified by staff groups that were interviewed during the course of the review.

Barriers	Levers
<ul style="list-style-type: none"> <li>• Moving services out of combined trust may increase instability?</li> <li>• Organisations have different objectives</li> <li>• Inertia regarding local and national elections</li> <li>• Separate budgets/ structures are barriers to the transfer of care</li> <li>• Different influences within each organisation</li> <li>• Governance arrangements differ and some more complex than others; what constraints will be imposed on future organisational structures?</li> <li>• Organisational configuration – willingness of community to see reduction of some services such as acute or different mgmt arrangements</li> <li>• PBR and move to national tariffs raises issues of viability of a number of Island services</li> <li>• Size of some services raises similar arguments for clinical viability</li> <li>• No level Playing field within HIOWSHA</li> <li>• Organisational structures get in way of joined up working – conflicting priorities</li> <li>• Culture – behaviours and values not necessarily aligned e.g. work in MH and LD good examples</li> <li>• Professional groups territorial</li> <li>• National agenda - options chosen may not fit the national strategy</li> <li>• Mainland partners around risk sharing arrangements</li> <li>• Speed and its effect on delivery of care and staff morale – too slow and the aim of improved patient care and service will be lost</li> </ul>	<ul style="list-style-type: none"> <li>• Staff support the HealthFit strategy</li> <li>• Finance – manage the resources of the island as a whole [can be achieved through organisational change or pooled budgets]</li> <li>• HR and development is a shared agenda</li> <li>• Children's Trust Agenda</li> <li>• Joint appointments</li> <li>• Means to enable integration are here now</li> <li>• Money – PBR, Choice etc</li> <li>• Perception of external agencies such as SHA</li> <li>• Education – unique opportunities arising for joint working and service</li> <li>• Public support</li> <li>• SHA very supportive, may be able to lever more change (potential barrier dependent on option chosen)</li> <li>• NSFs</li> <li>• Patient choice and PPI</li> <li>• Having an agreed vision</li> </ul>