
NHS Brent Provider Services

**Provider Services Development Programme:
Reporting the Review and Assessment of NHS
Brent Provider Services**

October 2007 – July 2008

*Developing as a World Class Provider of Community Based
Services*

Executive Summary

In October 2007, NHS Brent (in association with Partnerships UK (PUK)) embarked on a Provider Services Development Programme. By exploring the provision of its community based services, the PCT had two main aims:

- In line with its commitment to the local population, to examine the position of Brent's Provider Services in delivering services which are modern, accessible, responsive and relevant to the local population: Ensure services improve health and well-being, reduce health inequalities and make best use of resources.
- To respond directly to NHS Policy directions on the future organisation of community health services.

Local and National Context

The overarching ambition set out in the Operating Framework (08-09) is to improve the ability for local NHS bodies and the communities they serve to have greater autonomy, achieved in part, by them determining their own priorities. The Operating Framework explicitly encourages PCTs to review their requirements for community services and create an internal separation between the commissioning and operational provider functions of the PCT. In doing so, PCTs are encouraged to treat their in-house provider services in the same way they would other significant suppliers of health services

In July 2008, NHS London asked all PCTs to submit their plans for strengthening commissioning. As part of these plans, PCTs were asked to demonstrate how they are promoting the autonomy of their provider arms such that, by April 2009, credible plans for complete externalisation are in place.

As part of these proposals, NHS London has encouraged provider arms to consider sub-regional 'alliances', partly to build scale, and to accelerate the process for creating commissioning-only PCTs in London. Brent provider services sit within the outer North West London Sector, along with Ealing, Harrow and Hillingdon PCTs. The four PCTs have established a joint programme of work to look further at the area of provider services separation and explore how working together might help achieve the aim of strengthening community services. The first phase of work will establish a robust baseline of current services, readiness of each PCT to reach autonomous provider services status after 1 April 2009 and opportunities for more formal joint working through a provider services alliance.

Brent's population of 300,000 is extremely diverse. It is characterised by stark variations in levels of deprivation, significant health inequalities, a highly mobile population and a rich mix and range of cultures, ethnic backgrounds and languages. The demographics of the population and intentions of commissioners to increase the amount of care delivered in community settings presents clear opportunities for community based providers. However, as NHS Brent refines its own world class commissioning practices, it will be looking for its key providers to demonstrate their ability to be *world class providers*.

There are clearly many opportunities and challenges ahead for NHS Brent's Provider Services. These arise, first, in Provider Services' ability to demonstrate that it is delivering services that are clinically and cost effective; and second, in Brent Provider Services

delivering services that are sensitive to the diverse cultures and health needs of Brent's 300,000 population and that make a telling and demonstrable contribution to reductions in health inequality.

This report provides a detailed assessment of Brent's Provider Services in the light of the opportunities and challenges ahead. It results in recommendations about the future shape and nature of Provider Services going forward to inform discussions surrounding the development of an externalised organisation in partnership with Harrow, Ealing and Hillingdon Provider Services with the ultimate aim of becoming a world class provider of services to the local population of Brent.

The Provider Development Programme

NHS Brent has embarked on Module 1 of the Provider Services Development Programme with the purpose of reviewing the shape and nature of its provider portfolio, understanding its scope, level of performance and extent to which it adds value for money. The main aim of Module 1 of the Provider Services Development Programme is to inform the PCT's decisions about the make-up of the future portfolio of services of the Provider Services and the principal service challenges and opportunities ahead. A secondary aim is to identify any capability and capacity gaps that may be acting to impede the Provider Services from operating in a more business-like way.

Governance of the programme has been provided by the Provider Services Sub-Committee and day to day delivery has been provided by the Programme Working Team. This report presents the outcomes of **Module 1** of the Provider Services Development Programme which comprises the review and assessment of the 31 NHS Brent PCT provider services.

Analysis of Finance, Workforce and Activity Data

Analysis of finance, workforce and activity data enables Brent provider services to gain a good understanding of costs and resource utilisation compared to peers. As with many PCTs, challenges in data availability and quality need to be considered when comparing performance against peers. Considering data across a range of business indicators identifies the need to develop the infrastructure, systems and processes aimed at improving data quality and availability which enable Brent Provider Services to become competitive in the market place. Key headlines from the analysis of finance, activity and workforce information are as follows:

- NHS Brent has been particularly challenged to produce data of sufficient quality to properly inform the analysis required. Activities to improve systems and processes which will ensure accurate data is available will be informed by the findings of the Provider Services Development Programme
- NHS Brent plans to spend £37.08m on community services in 2008/9. Of this amount 97% is with its own community provider. The remaining 3% is spent with its neighboring PCT Providers. NHS Brent is atypical in its over-reliance on its own Provider for the provision of community services.

- In 07/08 Brent Provider Services received 9.1% of the overall PCT budget allocation which is larger than its immediate neighbors, Ealing and Harrow (at 5.9% and 6.2% respectively). The total proportion of spend on other community providers for Ealing and Harrow is not known at present but is worthy of future analysis.
- NHS Brent spends around 35% more per head of 1000 weighted population than Ealing with its Provider Services body. However compared to Ealing, NHS Brent has a slightly smaller population and a similar number of GP's per 1000 population.
- Five services within the Provider portfolio account for over 49% of the total provider expenditure. These are core PCT provider services (District Nursing, Intermediate care, Health Visiting, Peel Road Unit & Community LD & Day Service Teams and Children's Therapy Teams). A total of 27 other services make up the remainder of the PCT's portfolio which, whilst not unusual for PCTs, does present challenges both for management and operational sustainability of small services. Analysis of the maximum efficient scale of these 27 services is worthy of further work.
- NHS Brent Provider services receive £4.2m income from sources other than NHS Brent Commissioners. Income is received through block contracts for community services provision. Contracts do not provide the detail needed to allocate income to individual service lines. Further work is required to develop more detailed contracts with the identified Non NHS Brent Commissioners
- The analysis of income to Brent Provider Services identifies its own commissioners as the major contributor of income. Whilst this removes some complexity, it also poses challenges to both NHS Brent Provider and Commissioner. For a single borough Provider it presents risks in terms of over reliance on host commissioner and the financial risks associated with the potential loss of contracts if the main commissioner chooses to decommission or market test services. For the commissioner in the demonstration of competence as market shaper in its role as a world class commissioner of health services for the local population.
- Analysis of the provider cost profile shows that the provider budget comprises 51% pay costs, 13% non-pay and 36% indirect costs. This cost profile is significantly different to other PCTs in the PUK Programme, where indirect costs are accounting for between 15% and 30% of the provider total cost base. The high level of indirect costs may reflect both a large and expensive estate. Further work is required on the allocation of indirect costs.
- The large scale of the non-pay (includes direct and indirect non pay costs) results in the average total cost per WTE for Brent Provider Services significantly exceeding the total cost per WTE of peers (at £80,611, some 31% greater than the next highest and more than double the lowest). This presents significant challenges for Brent Provider Services as they take their place in a contestable market of community provision. A significant proportion of these costs are related to the estates costs allocated to Provider Services.

- The cost per contact across NHS Brent Provider services currently sits at £97 which appears high compared to peers. This requires verification following activities aimed at improving data quality and availability are implemented.
- Both pay and non pay expenditure have been reduced significantly over the last 18 months as a consequence of financial control measures. As a result, NHS Brent Provider services pay costs are the lowest within the benchmarking cohort, whereas activity levels per WTE are within the top three PCTs within the benchmarking cohort.
- From January to May 2009, the overall PCT sickness rate was 5.39% which is 0.89% above the national average (4.5%). Sickness rates by service identify that 50% of services have a sickness rate above 4.5%. These services are, in the main, the larger PCT Provider Services. Active management of sickness absence is now in place within Provider Services which will provide a better indication of the underlying issues of sickness absence.
- Due to the migration of workforce information to the Electronic Staff Record information system, the reconciliation of establishment to staff in post has not been possible by service line and data relating to turnover and vacancy rates by service line are also not available at this time. A workforce data set and reporting mechanisms need to be agreed at both Directorate and Service level to enable the proactive management of staff resource
- The PCT's asset base is comparatively high with a net book value of £52.7m and an asset turn of 0.9:1. In addition the revenue costs of supporting the estate (maintenance, rent and capital charges) are relatively high due to the presence of PFI and LIFT developments - the annual PFI tariff and lease plus payments being around £4 million.

Service review and assessment

Section Four of the provider development report presents a detailed analysis of the 31 service lines included within the current portfolio of Provider Services.

Service Cluster	Service Lines
Children's Services	Children's Medical and Children's Community Nursing Services (includes looked after children and audiology) Children's Therapy Services School Nursing Health Visiting Homeless Service
Learning Disabilities Partnership	Learning Disabilities (including Peel Road Unit, The Community Team for People with Learning Disabilities (CTPLD), The Community Activity Support Service (CASS))
Adult Inpatients, Community Nursing and Therapies, and Urgent Care	Intermediate Care and Rehabilitation Inpatient Wards Neuro-rehabilitation Inpatient Services Brent Rehabilitation Service (including Falls and Stroke) CMH A&E Front of House Wembley Walk In Centre District Nursing (including Out of Hours) Community Matrons Stoma Continence Nutrition and Dietetics
Adult Care Pathways and Outpatient Services	MSK Physiotherapy Podiatry Phlebotomy Brent and Ealing Wheelchair Services Substance Misuse Service Community Dental Service Care pathways: <ul style="list-style-type: none"> • Diabetes • Cardiology • Dermatology

	HIV Coordinator Primary Care Mental Health Service	• Respiratory Diabetic Retinal Screening Programme
Other	Infection Control Service Integrated Care Coordination Service (POPP)	

The Service Line Review process for individual services has used the following six-point framework of analysis:

- **Fitness for purpose** - testing commissioner support for the service, cost and quality, patient access and productivity of resources deployed;
- **Strategic fit of services** - examining inter-dependencies between services and the degree to which they contribute to the PCT meeting its own key priorities, as set out principally in the Commissioning Strategy Plan 2007-20;
- **Competitive intensity** - investigating the likelihood and impact of competition on the service, both from within and outside the NHS;
- **Risk** - assessing the level of clinical, operational and/or financial risk faced by the service, notably if there is a realistic prospect of market testing by PCT commissioners or PbC clusters;
- **Management challenge** - examining the scale of management effort required to deliver the service to its best potential;
- **Overall attractiveness** – examining the appeal of the individual service to a future autonomous provider organisation, based on an aggregation of the above analysis.

Based upon the findings of the individual Service Line Reviews conducted by Service Leads and analysis through the subsequent “Gateway Review” process, the PWT is able to make recommendations about service futures and, in particular, recommend whether an individual service line should be categorised as:

- i. **Category A** – be retained in the long term and developed by Provider Services as part of its core service portfolio.
- ii. **Category B** – be subject to a focused period of redesign and then re-assessed by BEN PCT and Provider Services within an agreed period to consider future long term inclusion within the provider portfolio
- iii. **Category C** – be conceded now to other providers or parts of the PCT.
- iv. **Category D** – should be discontinued and/or the PCT’s requirements substantially re-framed so that a significantly different service model results.

Table 4.6 Identifies which services fall into which categories

Table 4.6 Service Categories

Category	Service Line
Category A	<ul style="list-style-type: none"> • Brent and Ealing Wheelchair Services • Continence • Infection Control • Nutrition and Dietetics Service • Retinal Screening Service • Stoma • Children's Medical Service • Children's Community Nursing Services • Children's Therapy Services • Neuro-rehabilitation Inpatient Services • Substance Misuse Service • CMH A&E Front of House • Wembley Walk In Centre • Community Dental • Community Matrons • Phlebotomy (see note below) • Care Pathways: <ul style="list-style-type: none"> ○ CHD ○ Respiratory ○ Dermatology • The Community Activity Support Service (CASS) • MSK Physiotherapy • Primary Care Mental Health Service
Category B	<ul style="list-style-type: none"> • Brent Rehabilitation Service • District Nursing • Care Pathways: <ul style="list-style-type: none"> ○ Diabetes • Podiatry • School Nursing • Health Visiting • The Community Team for People with Learning Disabilities (CTPLD) • Intermediate Care and Rehabilitation Inpatients
Category C	<ul style="list-style-type: none"> • HIV Coordinator
Category D	<ul style="list-style-type: none"> • Peel Road Unit • Homeless Service

Each service is in the process of reviewing their development requirements and formulating individual service development plans based on the assessment of their service. These plans will be reviewed and integrated into the Provider Service Business Plan.

The majority of services have demonstrated that they are attractive for the Provider to continue to provide. However, it is important to note that these are recommendations for discussion, rather than the final view of the PCT. While a number of services may, for the provider, be highly attractive to continue to provide, there may be compelling reasons to integrate these services with other providers. Examples may be some children's services and the walk in centre. Integration with another organisation may have greater benefits for patients. Categorisation of services within the Provider Portfolio will inform discussion within the PCT and with potential Alliance partners regarding the nature and shape of the future Provider Portfolio as it develops as an Autonomous Provider Organisation. A range of conclusions may be reached from those discussions. These include:

- **Conclusion 1** - Recognise the challenges inherent in running, developing or strengthening a service, adopt the service as part of NHS Brent Provider Services in the long term and resolve to put in place appropriate solutions to those challenges; or

- **Conclusion 2** - Adopt the service as part of Provider Services in the short to medium term, but, in doing so, both NHS Brent and Provider Services commit to work together to address the challenges and to share risks in doing so. Equally, both NHS Brent and Brent Provider Services will, after an agreed period, formally re-assess whether significant headway has been made to resolve the challenges; or
- **Conclusion 3** - Choose not to introduce the service as part of the Provider Services portfolio.

Becoming and World Class Provider and Provider of First Choice

The ambition of NHS Brent Provider Services is to provide the best care possible to the population it serves by providing care which is sensitive to the diverse needs, cultures and characteristics of the population, is responsive to its health needs and reduces health inequalities; and at the same time is business like in its approach to the development and delivery of care services. To realise its ambition, assessment of the Provider Services' capabilities has taken place and gaps identified. Assessment of capability has been informed by examination and assessment of services against six key areas of analysis, analysis of finance, estates, workforce and activity data, discussions with key stakeholder and consideration of the findings of the service reviews with key PCT personnel.

In the main, the existing scope of the Provider Services portfolio is strategically well-aligned with commissioners' requirements for community health services. However, the review and assessment of services, undertaken as part of the Provider Services Development Programme, has identified that the majority of the core provider services, (comprising district nursing, health visiting, school nursing and in-patient services) require considerable development to ensure they deliver care which commissioners will, in the future, want to buy and invest in. Investment in and development of these services is underway and is being driven by a strong and credible management team.

Brent PCT Provider Services recognises that understanding its services and the capabilities needed to be the provider of choice in the local area is the start of a journey of development. This journey will only be completed when Provider Services uses learning gained from the work it has undertaken to examine its services to formulate a coherent and achievable development plan for the provider organisation as a whole..

Achieving effective separation between PCT commissioning and provider activities

The 2008/09 Operating Plan requires PCTs to separate their core commissioning activities from their provider activities. In this context, the term 'separation' describes a clear delineation of commissioning and provider activities. Whether this separation leads to externalisation is a matter which each PCT Board will determine, although NHS London requirements are clear.

The extent of separation can be described at three levels:

- Arm's length (separate governance arrangements within the PCT)
- Autonomous (own corporate functions within the PCT) and
- Externalised (complete independence from the PCT).

The introduction of the provider sub committee of the PCT Board prevents Brent's Provider Services from becoming a peripheral part of the PCT. Nonetheless, the PCT's strategic focus will be on developing world class commissioning competences. Operational management of services does not feature amongst these.

By allowing the Provider Services Sub-Committee to have an exclusive focus on providing community services provides the space, scope and incentive to develop world class community services, as a suitable analogue to Brent's world class commissioning ambitions.

Creating an APO to manage the delivery of community health services is expected to give rise to benefits for commissioners, for providers of services and, ultimately for users of health services.

Creating an autonomous Provider Services arm will not be a costless exercise. Three types of cost pressure are likely to be introduced: non-recurrent development costs, reallocated and new recurrent revenue costs. Illustrative costs are described within the body of this section.

Brent Provider Services has now completed Module 1 of its provider development programme and needs to determine its support requirements to move firstly to an APO. It will work collaboratively with Ealing, Hillingdon and Harrow PCTs on possible arrangements for an Autonomous Provider Organisation. There are a number of issues that will have to be worked through to achieve this.

Conclusions

The PCT commissioned a review of its provider services at its meeting in November 2007. This was in the context of PCTs needing to separate their commissioning and providing functions, and in particular to gain an understanding of the strengths, weaknesses and business context of particular provider service lines.

The context for PCT provider services has changed since the report was commissioned, in as much as:

1. NHS London has made it clear that it expects provider services to achieve autonomous provider status (APO) as soon after April 2009 as possible.
2. Commissioning organisations are expected to fully externalise their provider arms after APO status is achieved.
3. NHS Brent has entered with partner PCTs in Harrow, Ealing and Hillingdon a project to explore the option of creating a multi-borough APO. The exact terms of reference, governance and timescales for this work is in development.

There are some important findings in the report.

- Financial and activity information on community services is weak and underdeveloped, and this has hampered the completion of the work.
- Although the PCT spends a proportion of its income on community services which is consistent with its peers, it employs less community staff. There is evidence that

more Brent resources are tied up in estates and overheads and the model of service is clinic based rather than community based.

- Some of the most important and largest community services do not score well on fitness for purpose. The services that score well tend to be niche or specialist services.

The programme concludes by placing services into four categories. Those are: services to be retained in the long term by provider services as part of its core service portfolio, services which need a focused period of redesign and then re-assessment by commissioners and providers, services to be transferred now to other providers and services that should be discontinued or the PCT's requirements substantially re-framed so that a significantly different service model results.

It is important to note that these are recommendations for discussion, rather the final view of the PCT. While a number of services may, for the provider, be highly attractive to continue to provide, there may be compelling reasons to integrate these services with other providers. Examples may be some children's services and the walk in centre. Integration with another organisation may have greater benefits for patients.

Next Steps

On the basis of this report, the provider arm and commissioners will agree the action needed to ensure:

1. A clear and transparent process is designed leading to recommendations as to which services are continued in the provider portfolio, and which are transferred or re-commissioned.
2. That where services require further development to become fit for purpose there is a clear plan for doing so.
3. That the terms of reference of the provider development board are revised to take into account the completion of the PUK project and the need to incorporate the North West London Provider Alliance.

A report will be made to the next board meeting on how these issues are being taken forward.

Summary of Detailed Recommendations

Detailed recommendations aimed at developing NHS Brent PCT Provider as a fit for business and fit for purpose organisation have been articulated throughout this report. It is suggested that these recommendations should inform the ongoing Provider Services Development Programme.

Finance

1. Undertake further analysis of financial performance of Provider Services as a whole and individual service lines within the portfolio of services at the end of the year once a 2008/09 actual expenditure is available against the full year budget allocation.
2. Gain a comprehensive understanding of the source and volume of activity attributed to third party income. Allocate relevant income to associated service lines and reassess the potential impact of loss of third party income on individual service lines and Provider Services as a whole.
3. Gain a detailed understanding of the cost profile of Provider Services which should include the reassessment of indirect and direct cost allocation.
4. Gain a detailed understanding of the estate requirements of Provider Services. Make decisions regarding future estate ownership between NHS Brent Provider and Commissioner.
5. Develop an agreed protocol for the allocation of managerial and clinical posts to associated budget codes.
6. Gain a detailed understanding of the staffing costs associated with the delivery of front line services (which includes those staff allocated to the estates team which provide reception and admin duties).
7. Reconcile financial and ESR data of establishment and staff in post and review budget structures to reconcile the cost of establishment for each service.

Information and Performance

8. Improve the quality and completeness of activity data collected. Once completed, undertake further benchmarking work to determine a more accurate cost per contact.
9. Develop infrastructure and systems which will provide the data needed to define the Provider Services as a *fit for purpose* and *fit for business* organization.

Workforce

10. Review the Provider Requirements for workforce information and ensure that full use of ESR is made.
11. Develop a competency based management development training plan for Service Leads and Senior Managers within the Provider Arm based on individual and collective capability development requirements.
12. Review the role of Service Leads to ensure best use of clinical skills are made and ensure that clinical activity is attributed to clinical as opposed to managerial budget codes.
13. Develop a staff communications and engagement strategy to ensure the full engagement of staff in future service changes.

14. Gain and maintain a greater understanding of workforce competencies available within the workforce and the requirements of a future workforce. Develop and implement a Provider Services workforce development strategy.

Quality , Safety and Effectiveness

15. Develop and implement an outcomes framework which facilitates the calculation of cost benefit at individual service level.
16. Assess the impact of the low level of staffing resource on the quality of service delivery.
17. Develop quality plans for each service and the provider as a whole which facilitate the delivery of services which are of optimum quality and to provide a mechanism to evidence achievement and improvements in quality.
18. Ensure practices are in place to attain uniformity in the application of systems and processes which facilitate quality both within and across services.

Commissioning

19. Continue to develop purchaser/provider relationships with all key strategic commissioners and Practice based Commissioners in Brent.
20. Ensure mechanisms are in place for services to systematically obtain an accurate and up-to-date picture of commissioners priorities, intentions and plans and for commissioners to proactively receive information which assures them that services are delivering in line with commissioning requirements.

Business Infrastructure and Support Services

21. Examine Provider Services requirements for support services, determining which of these it needs to host within its own structure (for example, human resources, business planning, client relationship management, and business development capabilities), and which it wishes to commission from external sources.
22. Develop robust corporate support agreements which define the nature and cost of services provided, the outcomes required and measures of the performance achieved.

Provider Development and Marketing

23. Develop robust mechanisms for engaging patients and the public in service evaluation and design and implement across services within the Provider portfolio.

- 24.** Develop mechanisms for seeking the view of provider partners on the quality and effectiveness of Provider services delivery.
- 25.** Attain an in-depth understanding of the characteristics and strengths of potential competitors. Utilize this information to develop the Provider Services marketing strategy.
- 26.** Develop a provider strategic development plan which gives consideration to the future nature and content of the provider portfolio based on the assessment of current capabilities and delivery model. The plan should incorporate short, medium and long term business development opportunities.
- 27.** Ensure strategies to reduce clinical, financial and operational risks identified within individual services are included in service development plans and are prioritised for attention.
- 28.** Consider reviewing the names of some services to facilitate a better understanding of what the service aims to deliver.

CONTENTS

1.	INTRODUCTION AND CONTEXT	16
1.1	National Policy Context	16
1.2	Regional Policy Context	18
1.3	Providing Modern, Accessible and Effective Services to the Local Population	19
1.4	Opportunities and Risks for Community Health Services	22
1.5	NHS Brent within the Context of the Local Health Economy	24
1.6	Summary	25
2.	BACKGROUND, GOVERNANCE AND PROCESS OF DEVELOPMENT	26
2.1	Background and Governance	26
2.2	Programme Design	28
2.3	Module 1: Service Line Review and Assessment	28
2.3.1	Decision Support Framework	29
2.4	Reflection on the Completion of Module 1 within NHS Brent	31
2.5	Summary	32
3.	FINANCE AND WORKFORCE ANALYSIS	33
3.1	Financial Overview	34
3.1.1	Allocation of Resources from Commissioners to Brent Provider	34
3.1.2	Service Level Financial Analysis	37
3.1.3	Third Party Income	39
3.1.4	Provider Cost Profile	40
3.1.5	Activity Metrics	43
3.2	Workforce Metrics	44
3.2.1	Skill Mix	44
3.3	Tangible Assets	47
3.4	Summary	49
4.	SERVICE LINE REVIEWS – KEY FINDINGS AND CONCLUSIONS	52
4.1	Overview of Service Line Review Process	54
4.2	Limitations of the service assessments	55
4.3	Service Assessment Findings	57

4.3.1	Fitness for Purpose	57
4.3.2	Strategic Fit	64
4.3.3	Vulnerability to Competition	70
4.3.4	Risk	74
4.3.5	Management Challenge	77
4.3.6	Overall Assessment	79
4.4	Summary	82
5.	BECOMING A WORLD CLASS PROVIDER AND PROVIDER OF FIRST CHOICE	84
5.1	Brent Provider Services Future Vision	84
5.2	Summary	86
6.	ACHIEVING GREATER SEPARATION BETWEEN PCT COMMISSIONING AND PROVIDER ACTIVITIES	88
6.1	The Challenges of Creating an APO	91
6.2	The Costs of Creating an APO	91
6.2.1	Non-Recurring Development Costs	92
6.2.2	Re-allocated Recurrent Revenue Costs	92
6.2.3	New Recurrent Revenue Costs	92
6.3	The Next Stage for Brent PCT Provider Services	94
6.4	Summary	94
7.	CONCLUSIONS AND RECOMMENDATIONS	96
7.1	Conclusions	96
7.2	Summary of Detailed Recommendations	97
	Appendices	102
	Appendix 1 – Decision Support Framework	
	Appendix 2 – Service Summaries	
	Appendix 3 – General Practice Survey Summary	

1. Introduction and Context

NHS Brent (previously known as Brent tPCT) was established in April 2002 in direct response to Health Care Reform¹. As a PCT, NHS Brent commissions services on behalf of the local population and provides a range of community based services to the 300,000 residents within its borders.

In October 2007, NHS Brent (in association with Partnerships UK (PUK)) embarked on a Provider Services Development Programme. By exploring the provision of its community based services, the PCT had two main aims:

- In line with its commitment to the local population, to examine the position of Brent's Provider Services in delivering services which are modern, accessible, responsive and relevant to the local population: Ensure services improve health and well-being, reduce health inequalities and make best use of resources.
- To respond directly to NHS Policy directions on the future organisation of community health services.



1.1 National Policy Context

Policy intentions aimed at directing the role and function of PCTs were initially set out in "Commissioning a Patient Led NHS" (DH 2005) and then followed up in the Government's 2006 White Paper "Our Health; Our Care; Our Say – A New Direction for Community Services".

The White Paper reinforces two significant propositions about where PCTs should focus their strategic efforts. These are:

- i. The principal activity of PCTs is to **commission** health care services and, where relevant, social care for their resident populations.
- ii. PCTs need to **formally separate** their core commissioning activities from their provider activities and, from there, need to consider how, in the light of this separation, innovation and **best value in provision can be achieved**.

¹ Health Care Reform in England: Update and Next Steps (DH:2001)

In December 2007, the Department of Health (DH) published its 2008/09 Operating Framework which sets out planning priorities and processes over the next three years. It encourages PCTs to focus on developing world class commissioning as the lever for change on behalf of patients and the public. Five key areas for improvement have been identified, following consultation with patients and communities. These are:

- Improving cleanliness and reducing healthcare associated infections;
- Improving access (through achieving the 18 weeks target);
- Keeping people well, improving overall health and reducing health inequalities;
- Improving patient experience, staff satisfaction and engagement, and
- Responding to emergencies, such as a flu pandemic.

The overarching ambition set out in the Operating Framework is to improve the ability for local NHS bodies and the communities they serve to have greater autonomy, achieved in part, by them determining their own priorities. The Operating Framework explicitly encourages PCTs to review their requirements for community services and create an internal separation between the commissioning and operational provider functions of the PCT. In doing so, PCTs are encouraged to treat their in-house provider services in the same way they would other significant suppliers of health services.

"During 2008/09, all PCTs should review their requirements for community services and use this process to consider all the options for models of provision...from 1 April 2008, all PCTs should create an internal separation of their operational provider services, and agree SLAs for these, based on the same business and financial rules as applied to all other providers." – NHS Operating Framework (December 2007)

The publication of Lord Darzi's *NHS Next Stage Review – Our Vision for Primary and Community Care* (June 2008) provides greater clarity on some of the principles by which Community Provider Organisations will develop and operate. The Darzi report emphasises two important features which inform the development of NHS Brent Provider Services. These are:

- The requirement for improved integrated care provision between primary, community and social care providers. The Department of Health will pilot innovative ways of achieving integrated care which includes the creation of new Integrated Care Organisations.
- That staff will have the right to submit request to PCT Boards that they set up social enterprises and, if successful, are awarded three year contracts to do so. Staff who transfer to new social enterprises will continue to benefit from the NHS pension scheme. Staff recruited directly to the Social Enterprise Organisation will not have access to an NHS pension.

At the same time as setting ambitions for the development of the supply side in community health services, the Department of Health has been designing some important features of the demand and regulatory environment within which community health services will operate. A range of national policy developments, which enable World Class Commissioning to gain expression, have been launched over the summer months. The key features of these policies which will inform the development of Brent Provider Services include:

- The identification of market management as a core commissioning competence². Commissioners will be assessed against their ability to effectively develop competence in market management. PCT provider services may experience increased contract monitoring and/or tender activity as a result of commissioners developing capability in market management
- The development of procurement practice³ which encourages PCT Boards to determine a procurement strategy for large, novel, contentious or repercussive services and signals the establishment of the *Cooperation and Competition Panel*, which will need to satisfy itself that contracting authorities (such as PCTs) have complied with guidance. Improved procurement practice will require provider organisations to become more business- like in their response to competitive tenders
- Strengthening of Patient Choice⁴ which reflects on the system change needed to ensure people with Long Term Conditions have access to their provider of choice and sets out the more defined rules-based landscape – which is seeing an increasing amount of services being provided on a legally-enforceable basis. Development of the choice agenda will require purchasers of services to commission fit for purpose services across care pathways to ensure strategic coherence, systems working and aligned service development. Providers will need to establish robust relationships with others delivering related services within the supply chain to ensure the patient experience of services along a care pathway is seamless.

1.2 Regional Policy Context

In July 2008, NHS London asked all PCTs to submit their plans for strengthening commissioning. As part of these plans, PCTs were asked to demonstrate how they are promoting the autonomy of their provider arms such that, by April 2009, credible plans for complete externalisation are in place.

As part of these proposals, NHS London has encouraged provider arms to consider sub-regional ‘alliances’, partly to build scale, and to accelerate the process for creating commissioning-only PCTs in London. Each sector within London has submitted a plan which outlines their arrangements for future possible configuration. These proposed arrangements vary between PCTs entering into an alliance with one or more neighboring providers, standing alone as a provider entity (perhaps as a prelude to links with non-NHS bodies, such

² Commissioning Assurance Framework DH June 2008

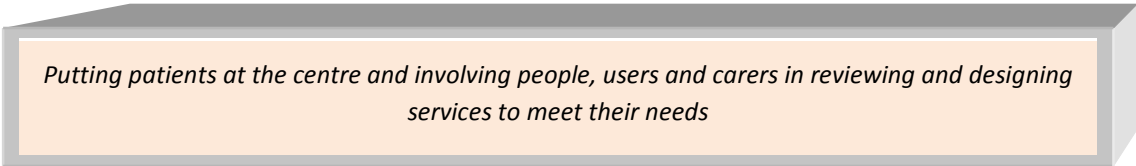
³ The PCT Procurement Guide DH May 2008

⁴ The Framework for Managing Choice, Cooperation and Competition. DH May 2008.

as the Local Authority or a Third Sector organisation) or engaging in a business transfer with another PCT in the sector.

Brent provider services sit within the outer North West London Sector, along with Ealing, Harrow and Hillingdon PCTs. The four PCTs have established a joint programme of work to look further at the area of provider services separation and explore how working together might help achieve the aim of strengthening community services. The first phase of work will establish a robust baseline of current services, readiness of each PCT to reach autonomous provider services status after 1 April 2009 and opportunities for more formal joint working through a provider services alliance.

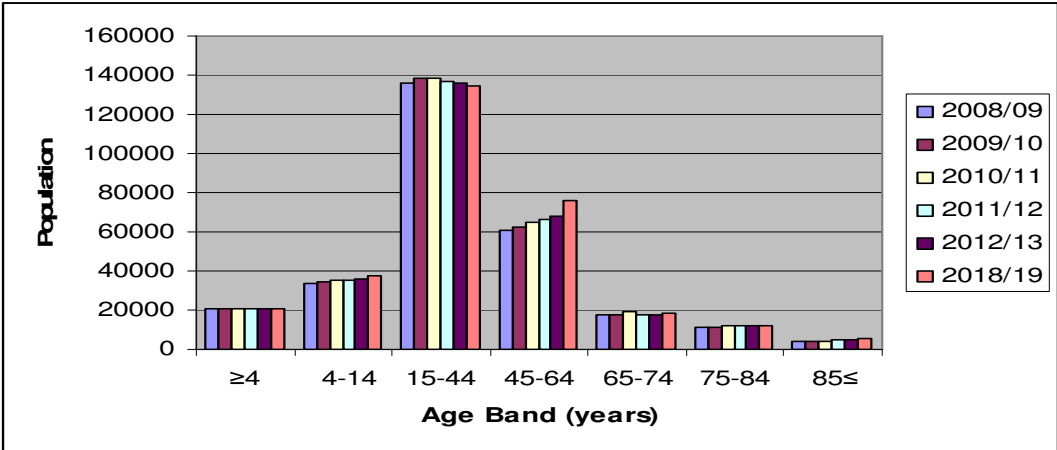
1.3 Providing Modern, Accessible and Effective Services to the Local Population



Brent has the greatest population density and is the 8th largest of the outer London boroughs with a population of approximately 300,000 residents. The population of Brent is expected to increase by 5% in the next 5 years and 7% in the next 10 years. This is 4.2% more than the overall expected growth for London as a whole (0.8%).

The greatest increases will be seen in people aged 45-64 and over 75 years of age. However, the 15-44 age group will continue to be the single largest population group⁵. The birth rate in Brent has risen by 3% each year over the last 7 years. Projected growth of Brent’s population year-on-year is illustrated in **Figure 1.0**.

Figure 1.0: Expected population growth by age band: London Borough of Brent (2008/19)



⁵ Public Health: Joint Strategic Needs Assessment. Brent tPCT. June 2008.

In addition to high population growth, Brent is one of the top 20 areas in the country to have experienced high levels of migration between mid-2001 and mid-2006⁶. The population comprises a large number of transient people and is extremely diverse, with over 130 languages spoken by the school age population⁷.

The population of Brent includes between 16,000 and 20,000 refugees and asylum seekers, representing approximately 8% of the total population. A recent study within the schools of Brent identified that a high proportion of children live in transient families, with 40% of children aged 10/11 not being in their current school or not in this country at the age of 5/6⁸. High rates for emergency admission and A&E attendances are linked to the way transient populations use NHS resources: many of them are not registered with GPs and do not have the knowledge to know how to access primary care services.

Dynamic population movements have resulted in Brent becoming one of the two most ethnically heterogeneous boroughs in the country. Black and minority ethnic (BME) groups make up the majority of the population (54.7%). In the next 10 years the BME population is expected to increase to 60% of the population. The largest increase is expected to be in the Asian population which is expected to increase to just under a third of the population (32%) by 2016.

Brent's population is one of the most deprived in the country and the fourth most deprived borough in outer London, having an IMD score of 25.95⁹ (2004). The Borough comprises five localities (**Figure 1.1**). The north of the borough is largely affluent suburbia, whilst in the south, wards such as Harlesden, Stonebridge, Kilburn and Kensal Green rank within the top 10% of most deprived wards nationally.

Figure 1.1: London Borough of Brent



⁶ *The Changing Demographic Picture of the UK. National Statistician's Annual Article on the Population. Population Trends, volume 130, Winter 2007.*

⁷ *Brent PCT Public Health report 2006*

⁸ *Brent Children and Young People's Plan 2006-09.*

⁹ *The normalised Indices of Multiple Deprivation Score (IMD) is 1. Anything above 1 shows a higher than average level of deprivation*

High levels of deprivation, diversity and mobility within the population of Brent are coupled with stark health inequalities. **Table 1.0** identifies the key health challenges faced by NHS Brent in the design and delivery of community health services.

Table 1.0: Health challenges linked to the demographics of Brent’s population and the implications for the design and delivery of community health services.

Feature	Key Health Challenges	Implications for Provider Services
Age Profile of the Population	<p>The number of births amongst Brent residents has increased steadily over the last 7 years increasing on average by 3% per year.</p> <p>The high refugee population means an increasing number of children with untreated disabilities are coming into the borough. Measles and mumps infections have shown steady increases over the last 2-3 years following the downturn in uptake of MMR vaccine. Brent’s high TB rate continues to increase due to its mobile population and the cessation of the BCG programme in school</p> <p>Stroke is the third most common cause of death and most common cause of adult disability. Mortality from stroke in Brent is similar to that in London as a whole, and is lower than mortality in England & Wales. Deaths from stroke have decreased nationally and in Brent between 2003 and 2006¹⁰. Nationally the prevalence of stroke is between 4 and 8 per 1000 population. The highest prevalence is in the Kingsbury locality which has the highest proportion of elderly people of all the Brent localities. Locally, there has been a very large increase (40%) in hospital admissions and stroke incidence (number of stroke acute events per year) of Brent patients for stroke between 2003/4 and 2006/7. Although mortality from stroke is decreasing the increased admission rates could be because of lowering of severity thresholds for admission and increased referral rates.</p>	<p><i>Children’s services will need to expand to respond to the growth in birth rates and number of children with disabilities. Consideration will need to be given to the way in which care is provided to a population which comprises significant numbers of transient and migrant people of diverse cultures, languages and health needs. Focused effort is required to ensure all children are offered and take up immunisations in line with the national childhood immunisation programme. Understanding and practices to control the spread of infection need to be embedded into service delivery and be a core element of health promotion interventions with the population.</i></p> <p><i>Caring for people with stroke requires both generic and specialist workforce skills. NHS Brent will need to assess if there is sufficient critical mass in stroke care to deliver specialist stroke services as a single community provider. There is likely to be increasing demand on specialist stroke based intermediate care and rehabilitation services, and generic district nursing and wheelchair services.</i></p>
Ethnicity	<p>The prevalence of diabetes in Brent is 4.6% which is higher than the national average. Diabetes is at its highest within the Black and Asian population being twice as common in the Asian population than in the White population (8.93% compared to 4.22%) The prevalence of diabetes is expected to increase by 20% to around 8.1% of the adult population by 2012. BME groups also exhibit higher levels of heart disease, hypertension and stroke with the age of onset of disease also being in earlier stages of life. Disease of the skin and bowel, the incidents of premature birth and disability and heterosexual HIV infection are also more prevalent within this group</p>	<p><i>Diabetes and CHD will continue to be major health issues for Brent in the future and will place demands on both primary care and acute care. Community services will need to demonstrate effectiveness in supporting primary care in the management of these conditions and in promoting preventative and self management strategies to patients. With growing numbers of children being born with complex life limiting disabilities and some children now developing type 2 diabetes due to obesity, demand on children’s services will grow</i></p>

¹⁰ Brent PCT information and public health departments, based on ONS mortality files

Feature	Key Health Challenges	Implications for Provider Services
Socio-economic profile/ Deprivation	<p>High levels of deprivation are a risk factor for a number of long term conditions, including cancer, chronic health problems in children, mental illness, skin infections. In addition, children living in poverty and areas of deprivation experience more tooth decay. In Brent, the mean proportion of five-year-old children whose teeth are decay free is 51.4%, well below the national targets of 70%.</p> <p>Circulatory diseases, including heart disease and stroke, and cancers are the most common cause of death in Brent. Overall, rates of these conditions are approximately equal to that of London, and less than that of England. However, mortality rates for these conditions are highest in the most deprived boroughs.</p>	<p><i>There are clearly significant health inequalities within the borough of Brent. Community services will need to understand and consider how such variations impact on the delivery of individual services. Workforce plans for each service will need to reflect variations in the mode and volume of service delivery required to reduce health inequalities and work with populations with diverse cultures, beliefs and languages</i></p>
Lifestyle Behaviors	<p>Of more concern than the actual current obesity rates are the future implications of poor diet and lack of exercise. Obesity is the second most significant contributory factor to ill health and preventable disease. Deprivation is often coupled with poor health behaviors which together link to health inequalities</p>	<p><i>Challenges exist for all services to embed strategies which support and encourage people to understand the impact of lifestyle behavior on their health and to develop healthier behaviors as a core element of all interventions with the population. Opportunities exist to develop lifestyle services which focus on health promotion and disease prevention</i></p>
Utilisation of Health Care Resources	<p>Some GP practice populations demonstrate a very high use of A&E services. Sixty seven percent of attendances were for musculoskeletal complaints, and only half of patients perceived their condition to be an emergency. The demand on Trauma and Orthopedic services remains high. Whilst much of the activity associated with inappropriate A/E attendance is associated with capacity and capability issues within General Practice, it is known that a large proportion of the population are not registered with a GP due to the transient nature of their residence within the borough. Ambulatory care conditions (conditions that could be managed in primary care) and High Intensity Users account for a significant proportion of admissions.</p>	<p><i>Brent Community Provider is commissioned to deliver a range of services which aim to reduce emergency admission and A/E utilisation. NHS Brent Commissioning intentions require the provider to strengthen such services and demonstrate effectiveness in targeting the population who are high utilisers of services and reduce reliance on emergency and urgent care.</i></p>

1.4 Opportunities and Risks for Community Health Services

A number of themes emerge from the analysis of need in and around Brent and from examining the NHS Brent Primary and Community Care Commissioning Intentions document (2007). These should critically influence the strategic choices made by Brent Provider Services about, for example, either growing existing or creating new services which are well aligned with future requirements and for withdrawing from services that are less well aligned.

Opportunities and risks arise as a result of:

- New and different needs emerging that succeed in altering previous commissioning priorities;
- Services responding to the need to meet existing commissioning priorities;
- Changes being required to existing models of care;
- Changes resulting from users, commissioners and providers improving their understanding of the clinical effectiveness and the cost effectiveness of current and new interventions.

NHS Brent's Primary and Community Commissioning Intentions (2008-09), identifies Brent Provider Services as having a key role in supporting the strategic shift of service from hospital-based care to care closer to home. Commissioning Priorities identified for community provision for 2008/09 are:

- Supporting reductions in emergency admissions
- Re-commissioning intermediate care and rehabilitation services
- Assertively managing people with long term conditions
- Supporting achievement in 18 weeks from referral to treatment
- Ensuring equity of access for all Brent patients
- Providing evidence based care which meet *Standards for Better Health*, represent value for money and meet all national and local targets including those set out in National Service Frameworks.

NHS Brent commissioners recognise the need to fully understand current community provision before making decisions about the future of individual services. Plans are in place for the PCT and Practice Based Commissioners to develop a robust commissioning plan for community services and support service reconfigurations resulting from the resulting commissioning decisions.

As the current provider of community services (predominantly commissioned by NHS Brent), Brent Provider Services is also in the process of examining its portfolio of services so that it clearly understands its capabilities and capacity to deliver in line with Commissioner requirements.

The Provider Services Development Programme has provided the framework for the review and assessment of services within the current portfolio of Brent Provider Services. It will enable the PCT as Commissioner of services and the PCT as the Provider of services to make informed decisions about the future of individual services and the nature and shape of Provider Services going forward as an autonomous provider organisation (APO).

In making decisions about the future nature and scope of the Provider Services of the PCT, NHS Brent has identified a number of key questions it would want to see addressed. These questions are identified in **Table 1.1**. **Table 1.1** also sets alongside these questions the key challenges for Brent Provider Services. The Provider Services' ability to meet these challenges is addressed as part of this report.

Table 1.1: Provider Considerations – Questions posed of Brent Provider Services

Key Questions	Implications for the provider
Can you measure what you do?	Brent PCT Provider will need to have a clear understanding of what interventions it delivers with what outcomes. Robust systems of information collection and performance reporting will need to be in place across all Brent community services
Do you provide services that Commissioners want to buy and invest in?	The Provider will need to understand commissioner's requirements for community provision alongside the quality and cost effectiveness of that provision. An honest assessment of services will identify gaps in safety, quality and value and the ability of individual services to deliver care in line with commissioning intentions
Are you able to provide services that can respond to changing needs?	Brent Provider Services will need to understand the skills and capabilities of its current workforce and the ability of the workforce to be flexible and responsive to changes in need. The Provider will need to understand its use of estate to deliver services and its ability to maximize the use of estate to deliver clinical services where appropriate.
Do you provide Value for money?	Brent Provider Services will need to understand its financial profile which will include the allocation of overheads across individual provider services. An understanding of the effectiveness and cost of services against peers will also need to be gained to enable Brent PCT Provider to demonstrate its value.
Do patients like your services?	Brent Provider Services will need to demonstrate that it is seeking patients views about service delivery and using that information to make changes to services which improve the service it provides to its customer

1.5 NHS Brent within the Context of the Local Health Economy

NHS Brent is situated in NHS London Strategic Health Authority (SHA). NHS London covers 32 London boroughs having a total population of approximately 7.2 million people, 13.5% of the population of England and Wales.

The NHS is one of London's largest employers, directly employing nearly 200,000 NHS staff (excluding workers in contracted out services). This represents 15-20% of England's total NHS workforce. The SHA comprises 73 NHS organisations which includes:



- **31 Primary Care Trusts** which at present commission and provide services
- **33 Acute Trusts** providers of healthcare services of which 9 are Foundation Trusts
- **8 Mental Health Trusts** including 5 Foundation Trust
- **The London Ambulance Service**

Within the borough of Brent there is one acute trust, North West London Hospitals NHS Trust (NWLHT), which provides services over 2 sites, Central Middlesex Hospital in the south of the borough and Northwick Park and St. Mark's Hospital in the north; and one mental health trust, Central and Northwest London Mental Health NHS Foundation Trust. The population of Brent predominantly receives acute services from NWLHT but also access acute services from acute hospitals in neighboring boroughs.

NHS Brent is bordered by 7 Primary Care Trusts, all of which provide community based services. These are:

- Harrow PCT to the northwest
- Barnet PCT to the northeast
- Camden PCT to the east
- Kensington and Chelsea PCT, Westminster PCT and Hammersmith and Fulham PCT to the southeast
- Ealing PCT to the south

Brent Provider Services has established both formal and informal partnerships with Brent Borough Council. The PCT and Brent Council work in partnership across a range of services, which includes Children's Services, Learning Disabilities, Older People's Services, Mental Health Services and Substance Misuse. In the case of Learning Disabilities there is a Section 31 agreement dating back to 2005 that is now subject to review. NHS Brent is geographically conterminous with Brent Borough Council.

An analysis of Brent's population and financial profile compared to its immediate neighbours is provided in **Section 3** of this report.

1.6 Summary

There are clearly many opportunities and challenges ahead for NHS Brent's Provider Services. These arise, first, in Provider Services' ability to demonstrate that it is delivering services that are clinically and cost effective; and second, in Brent Provider Services delivering services that are sensitive to the diverse cultures and health needs of Brent's 300,000 population and that make a telling and demonstrable contribution to reductions in health inequality.

This report provides a detailed assessment of Brent's Provider Services in the light of the opportunities and challenges ahead. It results in recommendations about the future shape and nature of Provider Services going forward to inform discussions surrounding the development of an externalised organisation in partnership with Harrow, Ealing and Hillingdon Provider Services with the ultimate aim of becoming a world class provider of services to the local population of Brent.

2. Background, Governance and Process of Development

2.1 Background and Governance

NHS Brent has worked with PUK to design and implement a Provider Services Development Programme. PUK is a body set up by the Government, and still almost half-owned by HM Treasury, to work solely alongside public bodies re-shaping themselves and, in particular, where this involves the public sector working in an increasingly business-like fashion.

PUK is working with fifteen other PCTs across the country helping them take forward broadly similar programmes. Brent Provider Services and PUK have pooled their distinct but complementary capabilities. PUK has introduced programme management disciplines, it has secured specialist 3rd party expertise to support the programme and it is itself providing commercialisation input.

Brent Provider Services has introduced service planning, management and delivery capabilities and experience; it has identified, co-ordinated and taken forward stakeholder management processes and it has executed appropriate programme governance arrangements.

For NHS Brent, programme governance responsibility for the Provider Services Development Programme sits with a sub-committee of the PCT Board; the Provider Services Sub-Committee (PSSC). The PSSC is chaired by Isabelle Iny, a Non Executive Director of the PCT.

Brent's PSSC is responsible for matters of performance, operations and development of the Provider Services as delegated by the PCT Board. Day-to-day operational performance is the responsibility of the [Interim] Director of Provider Services and Estates.

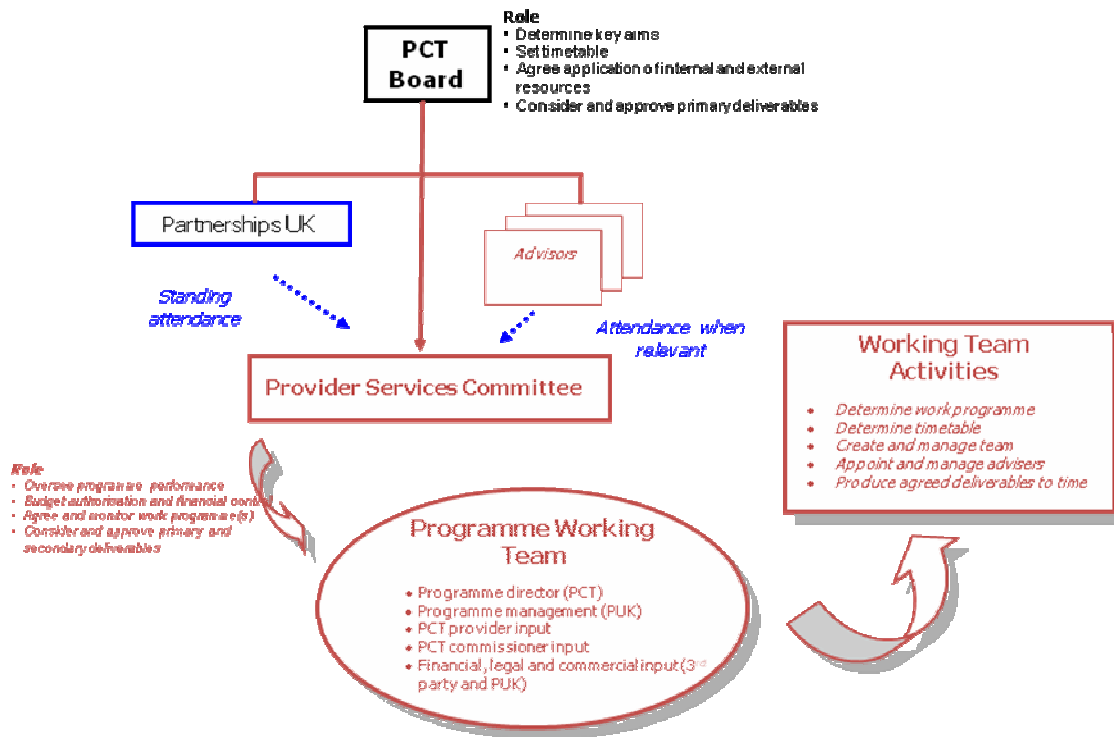
The Provider Services Development Programme has been organised so that substantial progress can be made under the auspices of the PSSC. However, the PCT Board will formally consider and agree progress made at a number of important points in the development programme.

The PCT Board's consideration will be critically informed by its roles as:

- i. Accountable authority for implementing national and local policy priorities.
- ii. Employer of staff affected.
- iii. Service commissioner and market regulator.

Figure 2.0 illustrates the programme governance and implementation arrangements that are currently in place.

Figure 2.0 – Governance and Implementation of the Provider Services Development Programme



A Programme Working Team (PWT) has been created to take forward the day-to-day work of the Provider Services Development Programme. The PWT is led by Jennifer Worthington, guided by Danielle Procter (PUK Project Director), with key members being the Assistant Directors of Provider Services and representatives from Finance, HR, Information and Communications support services. Part of the PWT's role is to provide, manage and/or procure the resources needed to complete the work programme.

The PWT has met regularly and frequently during the development programme. These meetings have been used to track progress, to consider decision-support tools, to answer questions and provide guidance, to co-ordinate input from outside of the Provider Services, including commissioners, the Finance Directorate and other corporate directorates, to service programme governance requirements and to direct next steps. At key stages, proposals and decision tools have been shared with, considered and endorsed by the PSSC

2.2 Programme Design

The Provider Services Development Programme has two distinct developmental activity streams. These are:

- i. Provider Fitness for Purpose - which is conducted largely through the Service Line Review process
- ii. Organisational Development - which is enabling the values and culture of Brent Provider Services to gain expression; for these to inform future provider arrangements and to identify skills and capabilities that need to be in place to create and sustain a successful organisation.

The Provider Services Development Programme is tri-modular in design. The end of each module is a point of genuine discontinuity, when NHS Brent can examine both the outcome of the module just completed, and the nature and timing of the following module.

The three modules are:

- **Module 1** – which includes mapping existing services, resources, future supply requirements and associated opportunities or threats and, in the light of this, developing plans for services (which may include either developing or withdrawing from provision);
- **Module 2** – which involves the introduction of greater separation between commissioner and provider, identifies and develops capabilities that support more autonomous management of Brent Provider Services and examines options for future organisational solutions for Brent Provider Services, which may lead to recommendations that result in the creation of one or more arms-length community health services enterprises;
- **Module 3** – which, if Module 2 recommends it, involves formulating and implementing start-up plans for an arms-length community health services enterprise.

NHS Brent embarked on **Module 1** of the Provider Services Development Programme with the purpose of reviewing the shape and nature of its provider service portfolio. The findings of this report will inform discussions about the future configuration of Provider Services which includes discussions regarding potential alliances and linkages with other community health service providers.

2.3 Module 1: Service Line Review and Assessment

The main aim of **Module 1** of the Provider Services Development Programme is to inform the PCT's decisions about the composition of the future portfolio of services for Brent's Provider Services, as well as identifying the principal service challenges and opportunities that lie ahead. A secondary aim is to identify any capability and capacity gaps that may be impeding Brent Provider Services from operating in a more business-like way. Such gaps might arise,

for example, from weaknesses in information, shortcomings in operating and performance management processes, shortfalls in professional leadership capacity and/or business development and operational delivery capacity and capabilities.

This decision support framework used in **Module 1** of the Programme aims to inform a number of significant decisions that the PCT Board will be required to make in relation to the future nature, shape and organisational structure of Brent Provider Services.

In order that decisions are soundly based, a decision support framework and set of tools have been developed by PUK. This framework has been used to support the Provider Services to clearly describe the scale, nature and quality of existing services and the outcome of their assessment. Tools within the decision support framework have been tailored, where appropriate, to reflect local circumstances. Quality assurance has been provided by PUK through the PUK Project Director, who also acts as a member of the PWT and the PSSC.

2.3.1 Decision Support Framework

The foundation of the decision support framework is provided by the Service Line Review process. This uses the following six-point framework of analysis:

- **Fitness for purpose** - testing commissioner support for the service, clinical and cost effectiveness, patient access and productivity of resources deployed;
- **Strategic fit** - examining the coherence of existing services both with each other and the extent to which they contribute to the PCT meeting its own strategic priorities,
- **Competitive intensity** - investigating the likelihood and impact of competition on the service, both from within and outside the NHS;
- **Risk** - assessing the level of clinical, operational and/or financial risk faced by the service, notably if there is a realistic prospect of market testing by PCT commissioners or PbC clusters;
- **Management challenge** - examining the scale of management effort required to deliver the service to its best potential;
- **Overall attractiveness** – examining the overall appeal of the individual service to arms-length Provider Services, based on an aggregation of the above analysis.

Appendix One sets out in more detail the components of each of the above criteria.

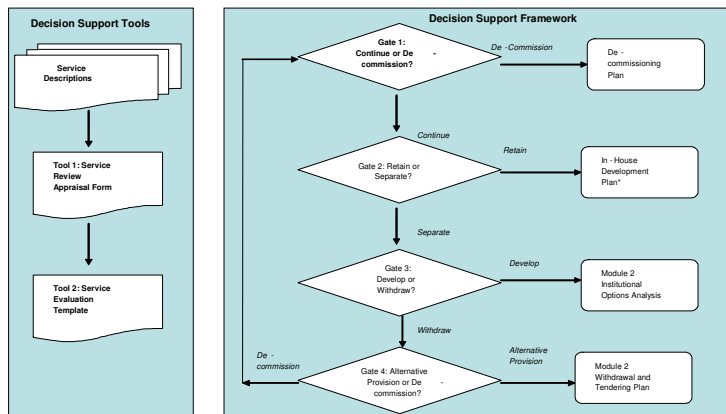
The work programme that supports the Service Line Review process is organised into four streams, which have been taken forward in parallel. These are:

- i. **Stream 1** - The internal review of the service line conducted by the Service Lead;
- ii. **Stream 2** - The timely production of relevant quantitative information on activity, human and physical resources and finance, including benchmarking information, completed largely by the PCT's corporate support services, with support, particularly for the benchmarking exercise, from Tribal Consulting;
- iii. **Stream 3** - The timely input of views from external bodies, such as commissioners, users and service partners;
- iv. **Stream 4** - The definition of a future vision for the Provider Services, informed by the analysis of current services and values of key stakeholders (such as commissioners and staff).

The Service Line Review process is organised so that it informs and supports **four key decision gates**. These gates represent the following sequence of decisions in relation to each service line (see **Figure 2.1**):

- **Gate 1** - Is the service a legacy service for which there is little or no commissioner appetite, or which is manifestly unsuited to achieve required clinical outcomes, and as a result should be *de-commissioned* in its current form
- **Gate 2** - If the conclusion of Gate 1 is "No", is the service a fledgling or vulnerable service, or would it be very difficult or risky to contractualise, and as a result should it be *retained* in the short to medium term within the PCT and not be separated out, irrespective of the form of an Arms-length provider
- **Gate 3** - If the conclusion of Gate 2 is "No", is the service one that the Provider Services is well-suited to provide and should therefore, seek to pro-actively *develop* as part of its future portfolio; or
- **Gate 4**: If the conclusion to Gate 3 is "No", is the service one the Provider Services is ill-suited to provide in the medium term and which therefore, should either be:
 - *Re-provided* by an alternative provider (possibly following a market testing process), or:
 - *De-commissioned* (and so referred back to Gate 1).

Figure 2.1 – Decision Flowchart



2.4 Reflection on the Completion of Module 1 within NHS Brent

Completing Module 1 of the Provider Services Development Programme has been challenging for NHS Brent. The PCT embarked on the Programme during an intense period of turnaround, as well as changes in senior management. Front-line staff were low in morale and short on trust that they would be included in decisions about the future of the services they delivered. However, Brent Provider Services (and NHS Brent as a whole) has strengthened its senior management capacity and capability over the last six months. This has had a positive effect and has encouraged service leads to engage in the review and assessment of the services they deliver and to seek to fully influence decisions about the future nature and shape of Brent Provider Services.

Relationships between the PCT's commissioners and providers are beginning to mature. As part of the programme, commissioners have given structured feedback to service leads on the performance and development of their services; Confirm and Challenge events enabled some service leads to engage with commissioners for the very first time. This has led to better understanding of services and requirements on both sides, and a modification of the purchaser-supplier relationship. These are both welcome developments and bode well for more meaningful discussions in the future.

During the Programme there has been a real sense that Brent Provider Services has developed and grown. There has been clear shift in the need to regain ownership of the performance and development of services and an acute grasp of the need for change to more business-like approaches.

There is a real appetite to show that Brent Provider Services, with their committed teams, can flourish in the market and that, central to this, is developing a better understanding of costs and cost-effectiveness and of benefits delivered, and to do this requires the capture of relevant activity and outcomes data. There is further work to be done in this area and the PCT is considering how to best provide support to Brent Provider Services in order to ensure that services can realise their full potential.

The completion of Module 1 has taken longer than anticipated due to the challenges encountered along the way. However the Programme has been successful in achieving its aims, as well as supporting Brent Provider Services to embark on its journey to

externalisation maturity and to harness the energy and enthusiasm of front line staff to deliver services that meet the needs of the local population in a clinically and cost-effective way.

2.5 Summary

NHS Brent has embarked on Module 1 of the Provider Services Development Programme with the purpose of reviewing the shape and nature of its provider portfolio, understanding its scope, level of performance and extent to which it adds value for money. Discussions under way regarding a potential alliance with Harrow, Hillingdon and Ealing Provider Services will be informed by the development of Brent Provider Services over the coming months. This will include decisions about future investment and/or market testing of different service lines.

The main aim of Module 1 of the Provider Services Development Programme is to inform the PCT's decisions about the make-up of the future portfolio of services of the Provider Services and the principal service challenges and opportunities ahead. A secondary aim is to identify any capability and capacity gaps that may be acting to impede the Provider Services from operating in a more business-like way.

Governance of the programme has been provided by the PSSC and day to day delivery has been provided by the PWT. The findings of the service line review and assessment process are presented in the following sections of this document:

- **Section Three** provides the assessment and analysis of finance and workforce metrics;
- **Section Four** provides the assessment and analysis of the service line reviews;
- **Section Five** provides a description of the future nature and shape of Brent Provider Services, underpinned by an assessment of the capabilities required to be a fit for purpose business;
- **Section Six** identifies the level of separation achieved to date between the PCT's Provider and Commissioning activities and articulates the benefits to Commissioners, the Provider and the local population from the Provider securing greater autonomy.
- **Section Seven** concludes the report, making recommendations for change and highlights the next steps in the development of Brent Provider Services

3. Finance and Workforce Analysis

To become a *world class provider* that is able to sustain competitiveness in the market place, Brent Provider Services needs to have a clear understanding of how it performs on cost and resource utilisation in comparison with its peers. Comparing performance against peers is a useful way of testing long-held assumptions, identifying areas where improvements can be made and communicating with commissioners.

Comparison is not, though, without its difficulties. The first challenge is simply to identify a cohort of relevant peers. Even if this is achieved, the second difficulty comes when trying to compare information that often lacks robustness and may not be like-for-like.

In considering the data and benchmarks presented in this section, a number of points need to be noted:

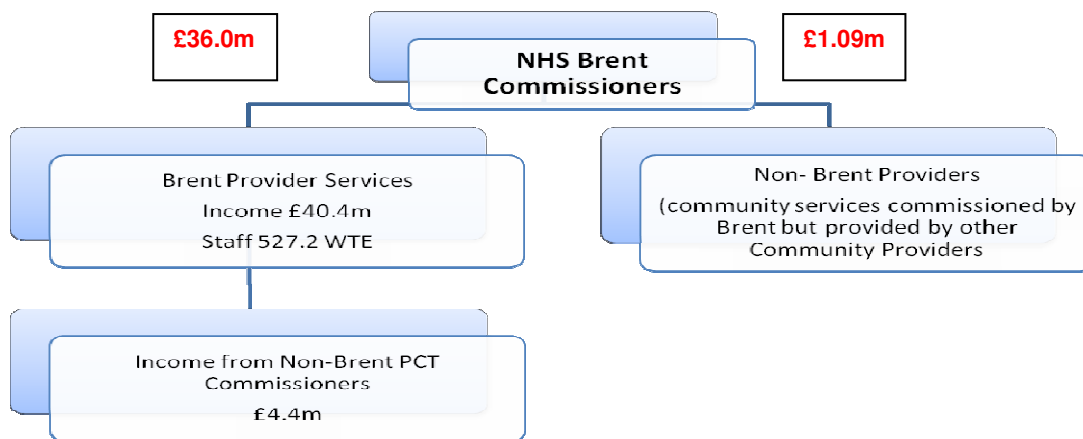
- I. The report presents an initial analysis of finance and workforce data attributable to the delivery of NHS Brent Provider Services. For Brent (as with many PCTs) this is the first time such analysis has taken place: the presentation of data and the subsequent analysis aims to act as a base-line for future analysis and to inform the development of Provider Services business processes.
- II. Provision of financial information for Brent was only available in relation to budget allocation for the period *2008/9*; comparison of *2007/8* budget against actuals do not provide an accurate picture of financial performance and as such has been excluded from this analysis. Further analysis is recommended once *2008/9* actuals are available.
- III. Metrics presented within this report have been drawn from a number of sources, principally the Provider Development Programme data book and resulting benchmarking template. This data has been supplemented by information taken from PCT published accounts. In some cases full information from peer organisations is not yet available for the purpose of benchmarking. Where differences in data sources are not felt to be material, they will be used for the purposes of benchmarking; such differences are noted in footnotes to the figures and tables.
- IV. NHS Brent has been particularly challenged to produce data of sufficient quality to properly inform the analysis required. As a result, this section of the report is not as comprehensive as that of other PCTs within PUK's programme. However, the process of developing this report has added focus to the approach NHS Brent is taking to develop the systems needed to provide service level data in the future. Notwithstanding the challenges presented by this exercise, it has been possible to examine some high level indicators by comparing NHS Brent with PCTs within the Public Services Provider Development Programme (supported by PUK). Reference has been made where challenges in data quality are felt to be material.
- V. The Provider Services Directorate comprises a portfolio of community clinical services and the PCT Estates team. This report aims to examine the portfolio of clinical services provided by the PCT Provider Services and as such workforce and

financial information relating to front line service deliver does not include the estates element of the Provider Services. Costs attributed to the estates function are captured in the calculation of indirect overheads.

3.1 Financial Overview

3.1.1 Allocation of Resources from Commissioners to Brent Provider

Figure 3.0¹¹ – PCT Spend on Community Services and Brent Provider Services Income (2008/9 budget)



In 2008/9 NHS Brent plans to spend £37.08m (8.3% of the PCT's total budget of £445m) on community services. Of this amount, the PCT plans to spend £36m (97%) with Brent Provider Services. The remaining £1.06m is used to commission services from other providers, notably Barnet (£0.88m), Camden (£0.12m), Harrow (£0.06m) and Islington (£0.01m).

Allocations for 2008/9 across comparator PCTs is not known, hence further analysis will be based on 2007/8 PCT allocations to their respective PCT Provider bodies

Table 3.0 provides a comparison of NHS Brent with its neighbouring Primary Care Organisations (PCO). The table presents population size and allocation of total budget by individual PCT to its own PCO Provider Services (source: 2007-8 annual report data).

Figure 3.1 presents in diagrammatic form the comparative allocation of total PCT budget to their respective in-house Provider Services bodies across the benchmark cohort (2007/8 financial year).

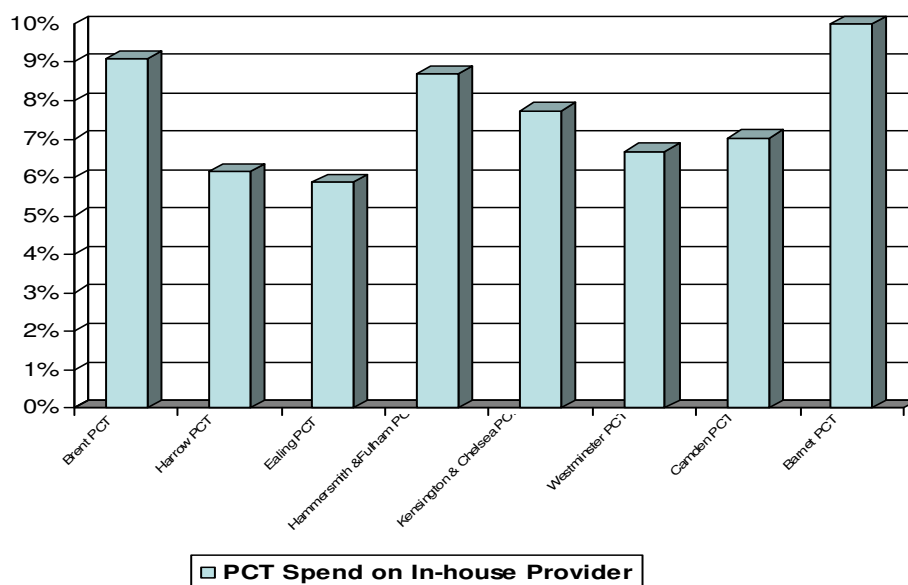
¹¹ The amounts in Figure 3.0 include pay costs, direct non-pay costs, provider overheads and a share of the PCT's own overheads, recharges and capital charges. Income and Expenditure figures have been sourced from the PCTs accounts for 2007/8. Whole Time Equivalentents have come from the PUK Consolidated Template and are budgeted staff numbers for 08/09.

Table 3.0 - Comparison of Brent PCT against its neighbouring PCO

PCO	Population (000's) ¹²	Total staff (WTE) ¹³	Total Spend £000's ¹⁴	Own Provider Services spend ⁴ £000's	% Spend with house Provider Services
NHS Brent	281,002	710	421,513	38,297	9.09%
Harrow PCT	214,800	491	265,977	16,385	6.16%
Ealing PCT	319,881	tdb	441,886	25,952	5.87%
Hammersmith & Fulham PCT	169,360	619	280,680	24,385	8.68%
Kensington & Chelsea PCT	188,945	tbd	277,048	21,434	7.74%
Westminster PCT	232,123	1,037	355,717	23,798	6.69%
Camden PCT	246,000	tbd	372,848	26,217	7.03%
Barnet PCT	370,000	1,232	455,652	45,544	9.99%

Note: 2007/8 financial accounts for Hillingdon PCT have not yet been published

Figure 3.1: Comparative allocation of total PCT budget to its provider Services (2007/8)



It is noteworthy, that in 07/08 the percentage income Brent Provider Services receives from its host commissioner (which sits at 9.1% of the overall PCT budget) is larger than its immediate neighbours, Ealing and Harrow (at 5.9% and 6.2% respectively). It is not known if Harrow and Ealing commission an overall smaller proportion of community services than Brent and/or if they commission a larger proportion of community services from community providers other than their own provider. It would appear (on first examination) that NHS Brent

¹² These are GP Registered populations, sourced from the PUK Consolidated Template for pathfinder PCTs and from annual reports and public health reports for PCTs that are not part of the Programme

¹³ WTEs sourced from the PUK Consolidated Template for pathfinder PCTs and from annual reports for PCTs that are not part of the Programme

¹⁴ Total and Provider spend refer to net operating costs and are sourced from annual reports

is atypical to its peers in being over-reliant on its own provider for a significant proportion of its community provision.

Table 3.1 presents further analysis by comparing a series of PCT spend metrics across the Provider Development Programme benchmarking cohort. Brent's nearest comparator in terms of weighted population is Ealing. NHS Brent spends around 35% more per 1,000 head of weighted population than Ealing with its Provider Services body. However, compared to Ealing PCT, NHS Brent has a slightly smaller population and a similar number of GPs per 1000 population.

Table 3.1 – Population Spend Metrics across the benchmarking cohort (2007/8)¹⁵

Population metrics	Brent ¹⁶	West'ster	Ealing	H'smith & Fulham	Hounslow	Ken'ton & Chelsea	BEN
Resident population	281,002	230,000	303,000	177,000	212,000	184,000	440,000
Weighted resident population	303,476	245,300	334,298	172,440	223,880	194,077	447,276
Morbidity Weighting multiple	109%	107%	110%	97%	106%	105%	120%
PCT Spend on community services (£m)	37.08m	£36.00	TBD	£25.20	£18.30	TBD	£49.50
% spend on community services with in-house Provider Services	97%	72%	TBD	90%	76%	TBD	78%
Total Provider Services cost base (£m)	£40.4	£32.70	£34.80	£24.40	£15.10	£27.90	£41.10
PCT spend on community services per 1,000 weighted population	£124,556	£146,759	TBD	£146,138	£81,740	TBD	£110,670
Total Provider Services budget per 1000 weighted population	£133,312	£133,306	£104,099	£141,498	£67,447	£143,757	£91,890
GPs per 1,000 weighted resident population	0.55	0.52	0.57	0.56	0.59	0.47	0.53
Average number of GPs per practice	2.36	1.95	2.08	2.69	2.08	1.88	2.8

There are currently 168 GPs in 72¹⁷ practices providing primary care services to the population of Brent [of which 19 are single-handed practices]. This equates to 2.36 GPs per practice with an average list size of 1673 (if all residents within Brent were registered with a GP): 0.55 GPs per 1000 weighted population. The latter metric is comparable with that of Brent's nearest neighbour, Ealing (0.57 GP's per 1000 pop). Brent PCT faces many challenges in relation to the local population's access to quality primary medical services. The quality of care provision and access for patients to see a GP or Nurse is variable; practices are challenged by a higher than national average practice population turnover of 20% per annum, significant diversity and high levels of deprivation within the presenting population.

¹⁵ Sourced from PUK benchmarking data, PCT annual reports and Allocation Working Party reports

¹⁶ 08/09 data

¹⁷ Sourced from 2007/8 annual report

NHS Brent continues to address the need to build capacity and capability in primary care whilst educating the local population on how to make best use of NHS resources. The challenge being addressed is not insignificant. Over the years, NHS Brent has felt obliged to develop its own services (such as the Walk-In-Centre and the GP-led minor injuries facility - 'Front of House' Service) which effectively satisfy demand that should be dealt with more appropriately in primary care settings. The level of quality care provision in primary care has an impact on the efficiency and effectiveness of community nursing and health visiting services. To gain maximum efficiency and effectiveness in care provision, the service delivery models for these services were changed from the GP attachment to the geographical model of working. The geographical model of working is currently being challenged by Practice Based Commissioners the implications of which will be identified in **Section 4** of this report.

3.1.2 Service Level Financial Analysis

Brent Provider Services activities can be clustered into five main service groupings, comprising 31 discrete Service Lines, namely:

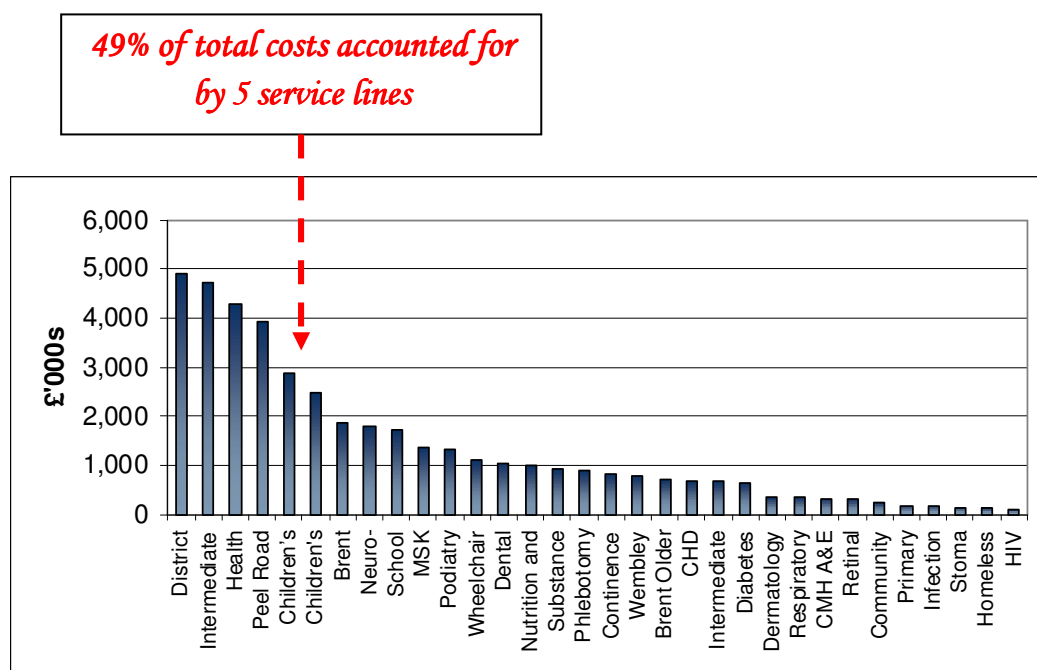
- Children's Services;
- Learning Disabilities Partnership;
- Adult Inpatients, Community Nursing, Therapies & Urgent Care;
- Adult Care Pathways & Outpatient Services and
- Other Services.

Table 3.2 – Composition of Service Clusters

Service Cluster	Service Lines
Children's Services	Children's Medical and Children's Community Nursing Services (includes looked after children and audiology) Children's Therapy Services School Nursing Health Visiting Homeless Service
Learning Disabilities Partnership	Learning Disabilities (including Peel Road Unit, The Community Team for People with Learning Disabilities (CTPLD), The Community Activity Support Service (CASS))
Adult Inpatients, Community Nursing and Therapies, and Urgent Care	Intermediate Care and Rehabilitation Inpatient Wards Neuro-rehabilitation Inpatient Services Brent Rehabilitation Service (including Falls and Stroke) CMH A&E Front of House Wembley Walk In Centre District Nursing (including Out of Hours) Community Matrons Stoma Contenance Nutrition and Dietetics
Adult Care Pathways and Outpatient Services	MSK Physiotherapy Podiatry Phlebotomy Brent and Ealing Wheelchair Services Substance Misuse Service HIV Coordinator Primary Care Mental Health Service Community Dental Service Care pathways: • Diabetes • Cardiology • Dermatology • Respiratory Diabetic Retinal Screening Programme
Other	Infection Control Service Integrated Care Coordination Service (POPP)

Figure 3.2 shows the distribution of Brent Provider Services 2008/9 budget by service line

Figure 3.2 : The distribution of Brent Provider Services 2008/9 budget by service line



The five largest service lines account for 49% of Brent Provider Services 2008/9 budget (see **Table 3.3**). The remaining 51% is spread across 27 smaller services.

This profile is fairly typical of PCTs within the PUK programme. Small services do though present significant operational challenges and PCTs need to question whether such services should continue to operate discretely or whether, for quality, risk or operational management reasons, they should either be grouped alongside other services or divested. Such issues are explored in **Section Four** of this report.

Table 3.3 – Brent Provider Services 2008/9 Budgets (inc pay, non pay and indirect cost allocation)

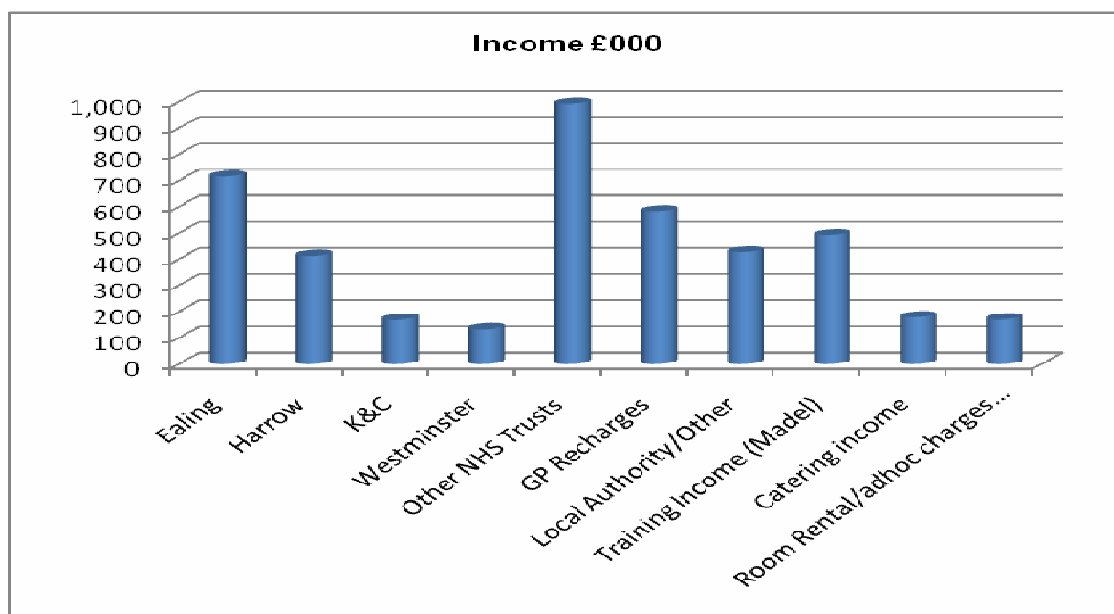
Service line	2008/9 budget	
	£'000	%
District Nursing (inc twilight service and nights)	4,538	11.4%
Intermediate Care and Rehabilitation inpatient wards	4,417	11.0%
Health Visiting	4,009	10.0%
Peel Road Unit + Community LD team and Day Service Team	3,644	9.2%
Children's Therapy Services	2,673	6.7%
Other	20,605	51.7%
Total	39,886	100%

3.1.3 Third Party Income

In 2008/9 Brent Provider Services expects to receive income of £4.4m¹⁸ from third parties. This level of income is comparable with peers in the PUK programme. Third party income is generated by providing community services to other PCTs and the Local Authority or by re-charging other bodies for use of Brent Provider Services premises. At present, the income received by Provider Services is through block contracts with neighboring PCTs. Work is underway to understand the nature and level of service which attracts income. This will allow the allocation of income to be attributed to individual service lines, the cost of the service calculated and robust contractual arrangements to be put in place with respective commissioners of those services. There is a risk that the absence of accurate activity data linked to income may lead to withdrawal of income from third parties if evidence of provision against income is not available. Further analysis to understand the impact of loss of income from commissioners other than NHS Brent is worthy of attention once the allocation of service level income has taken place.

Figure 3.3 shows the main commissioners that account for the Provider Services' third party income.

Figure 3.3 – Provider Services Sources of 3rd Party Income (£000's)



¹⁸ Sourced from PUK Consolidated Benchmarking Template

The analysis of income to Brent Provider Services identifies its own commissioners as the major contributor of income for the provision of clinical services. Whilst this removes some complexity, it also poses challenges to both NHS Brent Provider and Commissioner; for a single borough Provider it presents risks in terms of over reliance on host commissioner and the financial risks associated with the potential loss of contracts if the main commissioner chooses to decommission or market test services. For the commissioner in the demonstration of competence as market shaper in its role as a world class commissioner of health services for the local population.

3.1.4 Provider Cost Profile

Figure 3.4: Brent Provider Services Cost Profile

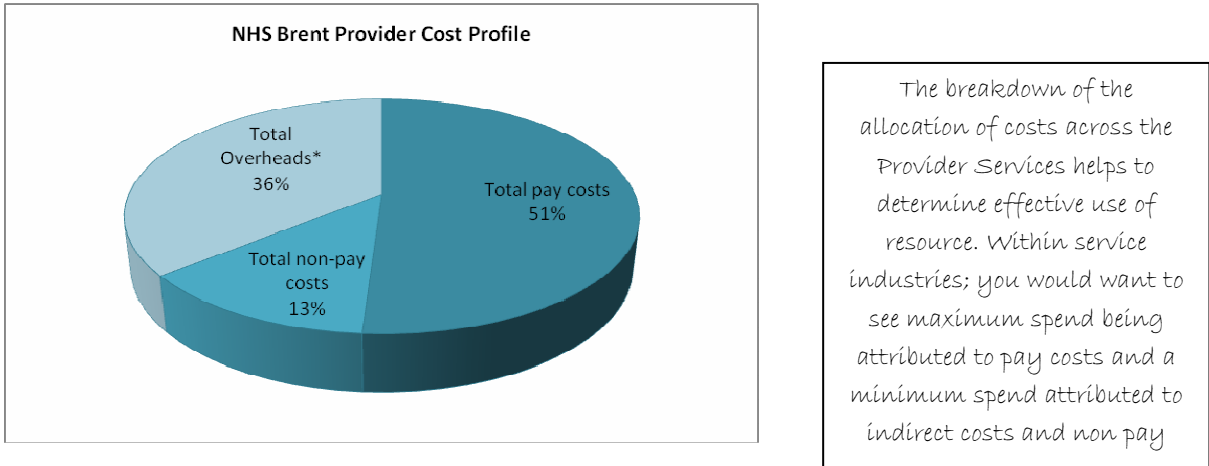
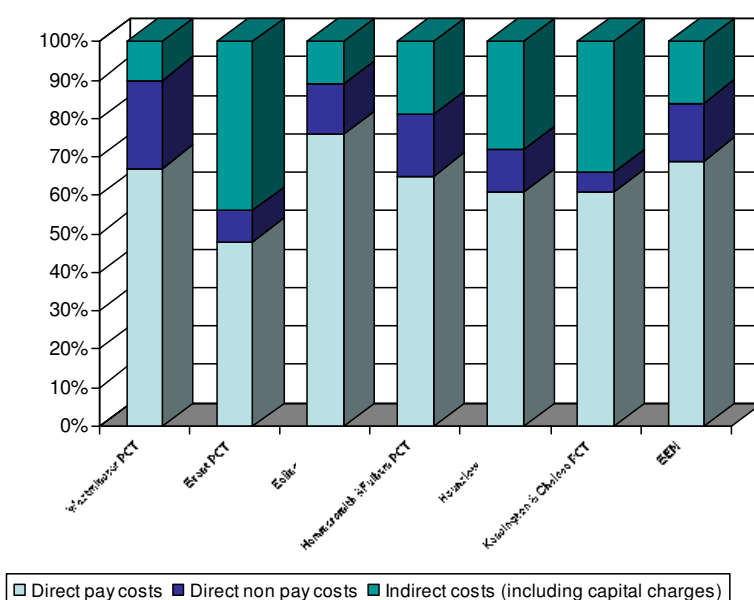


Table 3.4: Breakdown of Cost Profile

Budget heading	£'000	%
Clinical Staffing	17,214	43.16
Management and administrative staffing	3,314	8.31
Total pay costs	20,528	51.47
Clinical Services and Supplies	2,015	5.05
General Supplies	230	0.58
Establishment Expenses	1,826	4.58
Direct Premises Expenses	194	0.49
Sundry costs	751	1.88
Total non-pay costs	5,016	12.58
Total costs (Pay + Non Pay, excl overheads)	25,544	64.05
Capital Charges	2,680	6.72
Building Running Costs	8,353	20.94
HQ Recharge	2,315	5.8
K & C Service Contract	994	2.49
Total Overheads*	14,342	35.96
Total costs (with overheads)	39,886	100.00

Budgeted pay costs (2008/9) account for 51% % of Brent Provider Services' total costs. This is a significantly lower proportion than the average for other PCTs in the PUK programme (see **Figure 3.5**).

Figure 3.5: Brent Provider Services Cost Profile



Not only is the proportion low, Brent Provider Services direct pay establishment is also low (at 527 budgeted WTEs) by comparison to other PCTs in the Programme. **Table 3.5** shows that the number of WTEs per 1,000 weighted population in Brent is the lowest amongst the cohort. It should be noted that the direct front line establishment for the delivery of front line services equates to 527 WTE plus a proportion of the remaining 102 WTE admin, reception and estates staff. The total provider budgeted WTE is 629 WTE. Further work is required to understand how many of the total Provider Budgeted establishment (629WTE) are attributable to the delivery of front line clinical services before the true cost of services can be calculated.

Table 3.5: Direct Staff Costs in Brent Provider Services

Population metrics	Brent	W'minster	Ealing	Hounslow	K&C	BEN
Weighted resident population	303,476	245,300	334,298	223,880	194,077	447,276
Direct staffing establishment	527	701	755	404	455	934
Provider Services WTE staff per 1,000 weighted population	1.74	2.86	2.26	1.80	2.34	2.09
Total Provider Services cost per direct WTE	£80,611	£46,598	£46,094	£37,428	£61,340	£44,041

The large scale of the non-pay (includes direct and indirect non pay costs) results in the average total cost per WTE for Brent Provider Services significantly exceeding the total cost per WTE of peers (at £80,611, some 31% greater than the next highest and more than double the lowest). This presents significant challenges for Brent Provider Services as they take their place in a contestable market of community provision. A significant proportion of these costs are related to the estates costs allocated to Provider Services

Table 3.6 – Financial Metrics across the Benchmarking Group

Financial Metrics	Westminster	Brent	Ealing	H'smith & Fulham	Hounslow	Ken'ton & Chelsea	BEN
Pay costs as % of total budget	67%	51%	76%	65%	61%	61%	69%
Direct non pay	23%	13%	13%	16%	11%	5%	15%
Clinical staffing costs as % of total budget	57%	43%	75%	58%	56%	56%	59%
Management and admin staffing costs as % of total budget	10%	8%	TBD	7%	5%	5%	9%
Overheads, depreciation and capital charges as % of total cost (indirect costs)	11%	36%	11%	19%	28%	34%	16%
Net Asset Value @ 1st April 2007 (£m)	£58.70	£71.80 ^a	£28.50	£19.10	£17.60	£102.60	£16.40
Asset turn	0.56	0.66 ^a	1.22	1.28	0.86	0.27	2.59

a = During 2007/8 Brent PCT's estate reduced by £18m and now stands at £52.7m, which would leave an asset turn as 0.90

Direct non-pay costs represent 13% of total costs. Most of this (5% of total costs) is accounted for by clinical services and supplies (which total £2.0m). Anecdotal evidence from Service Leads suggests that non-pay budgets have been used occasionally to fund pay costs where short term staff shortages have been particularly acute.

Direct non-pay costs vary considerably across the benchmarking cohort. At 13%, Brent's non-pay costs are amongst the lowest in the benchmarking cohort, Kensington & Chelsea being the lowest at 5% and Hounslow at 11%. However, this could be explained by coding differences for non-pay items.

Brent Provider Services' management and admin staffing costs represent around 8% of the cost base, which is the second highest in the benchmarking cohort. These costs include some service level management and admin resources. This figure may increase once the admin and reception element of the residual 102 WTE which is felt to contain reception and admin as well as estates staff is better understood. The cost of the Provider Service central management (Director, Assistant Directors), admin and estates team are included in the calculation of provider indirect costs. Further work is required to allocate these costs appropriately to individual service lines or to Provider direct costs.

Coding of service level management resource and the inclusion of child health admin support to children's services is felt to account for the high level of management and admin costs. In many PCTs service leads have both a direct patient care and managerial role which allows a reduction in management overheads at service level. The role of Service Leads and coding methods in Brent are variable across services and require review to enable the true cost of management and admin resource to be calculated. A review of the role, function and

resulting coding of service level managerial posts may see a reduction in management costs and perceived increase in efficiency and attractive in a contestable market.

A fair and transparent allocation of indirect costs (typically known as overheads) to Provider services is essential if the true cost of service provision is to be calculated. Allocation of indirect costs between the PCT and Brent Provider Services has been based on Directors estimating the proportion of time spent by each corporate function on Provider business. Due to tight timescales and the volume of work required, high level estimates have been used to apportion indirect costs between individual service lines. It is recommended that the allocation of indirect costs to Provider service required further development and discussion.

At £16.3m indirect costs account for 36% of Brent Provider Services total cost base. This is a higher proportion than is being seen elsewhere in the PUK Programme. Typically, indirect costs are accounting for between 15% and 30% of total cost base.

Estates costs and capital charges make up the lion's share of Brent Provider Services indirect costs with the provider being allocated the vast majority of the costs incurred by the PCT as a whole. These total £11m per annum or 68% of total indirect costs. Typically in the PUK Programme, providers are being allocated between 40% and 55% of the PCT's total indirect costs.

If it is to be competitive in a contestable market, Brent Provider Services will need to fully recover all costs, direct and indirect, that are attributed to it. It will also need to ensure that the amount it pays for support services is commensurate with the quantity and quality of service required. Further work to understand its associated indirect costs is under way. As we move towards APO status and externalisation, Provider Services will need to operate in an increasingly business-like fashion and will need to examine:

- What it requires from its business support services;
- How these services are provided from within the APO structure (for example, human resources, business planning, client relationship management, and business development capabilities);
- Which services the APO may wish to commission from external sources;
- Which facilities it needs to occupy and at what cost;
- What environmental standards are required from the facilities occupied.

3.1.5 Activity Metrics

Table 3.7 presents contact data for Brent Provider Services and compares it to contact information collected from other PCTs in the programme. Although the number of contacts is not a reliable measure of activity and the accuracy of contact data is known to be problematic, for many PCTs this figure represents all that is collected at an aggregated level.

Setting caveats to one side, Brent Provider Services delivers around 436,520 patient contacts each year (just over 8,000 contacts each week). The average cost of each contact is £97 which is considerably higher than Brent's nearest comparator (Ealing sits at £59 per contact). The calculation of the cost per contact is a crude measure but the disparity in cost

per contact demonstrates the need to improve the quality of activity data and resolve issues relating to the allocation of indirect costs at service level.

Table 3.7 – Activity Metrics across the benchmarking group

Activity metrics	Brent	West-minster	Ealing	H’smith & Fulham	Hounslow	Ken’ton & Chelsea	BEN
Total number of contacts	436,520	424,879	587,862	187,412	57,124	40,010	572,689
Average number of contacts per 1,000 weighted population	1,438	1,732	1,758	1,087	255	206	1,280
Average Provider Services cost per contact	£97	£77	£59	£130	£264	£697	£72

With an increasing need to demonstrate cost effectiveness, improving the quality and completeness of activity data should be a key priority for Provider Services. Further benchmarking will need to be conducted and used to inform whether the crude cost of care, at £97 per contact, is attributable to the quality of data or perhaps signals low productivity levels or, an unsustainably large indirect cost burden, or a combination of the three. It might also reflect a service mix that is more complex or inpatient based than is being dealt with elsewhere.

3.2 Workforce Metrics

Providing and assembling workforce data has been particularly challenging for Brent due to the lack of capacity and capability to interrogate and quality assure data held within the new workforce information system; the Electronic Staff Record (ESR). Hence the data presented within this section is limited and has been mainly drawn from financial data relating to budgeted establishment.

3.2.1 Skill Mix

Figure 3.6 - Clinical: Managerial and Admin posts

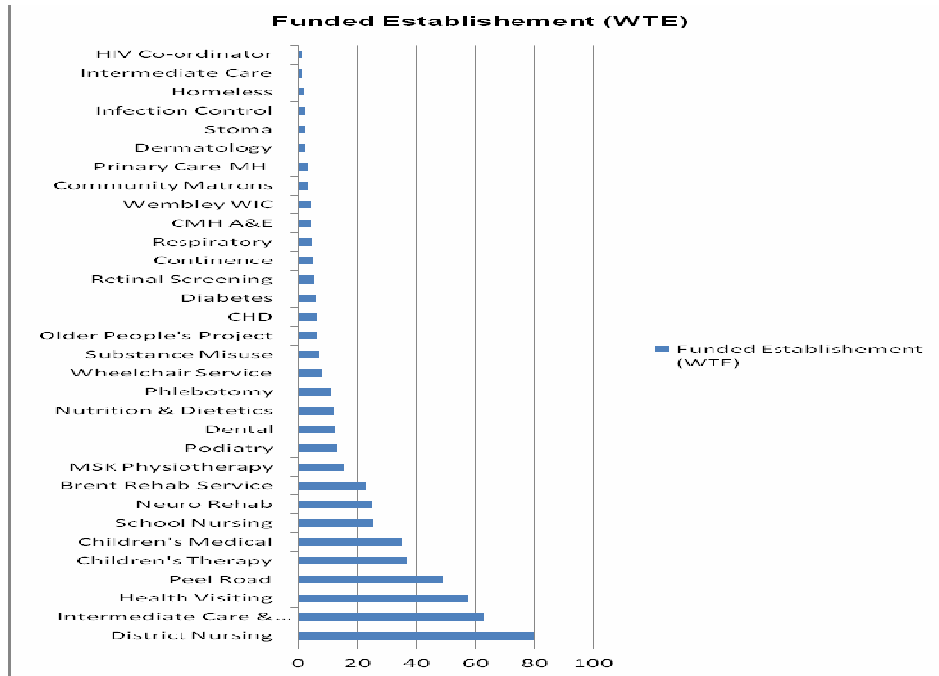


The Provider Services’ funded establishment for 2008/9 totals 527 WTE posts¹⁹, of which 84% are clinical posts and 16% management and admin. Challenges with reconciling

¹⁹ Estates, reception and general admin staff and the Senior Management team are not accounted for in this figure and equate to 102 WTE

budget structures at service level within the PCT and the migration of staff data to the ESR prevents the comparison of staff in post to funded establishment. **Figure 3.7** presents funded establishment by service.

Figure 3.7 – Funded Establishment



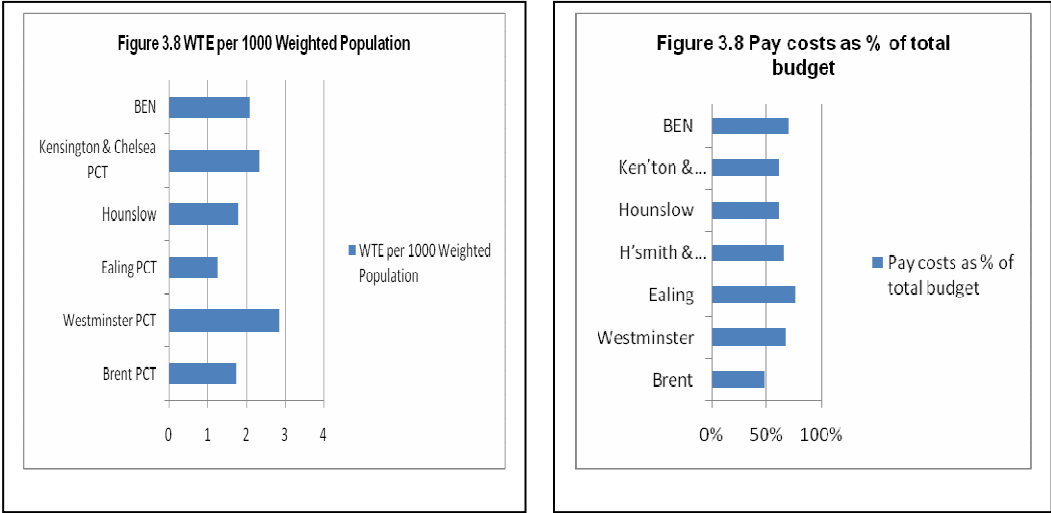
A reduction was made to funded establishments as part of the financial control measures undertaken in 2007/8. Savings were made through staff turnover and by removing vacant posts within services rather than an extensive programme of redundancies. The impact on service provision is discussed in more detail in **Section Four** of this report. **Table 3.8** shows the reductions in Provider staff between July 2007 and July 2008, part of which is accounted for by the transfer of services and staff at Kingsbury Hospital to Central and North West London Foundation Trust.

Table 3.8 – Turnover for Staff-in-Post July 2007 to July 2008 (note: these figures are for total Provider Services staff)

Staff Group	Jul-07	Jul-08	Fall in WTEs	% of Fall in WTE's	Turnover %
Additional Clinical Services	87.68	68.52	19.16	28.00%	26.80%
Administrative & Clerical	150.03	129.75	20.28	16.00%	21.00%
Medical & Dental	22.59	21.10	1.49	7.00%	31.00%
Nursing & Midwifery	219.92	185.71	34.21	18.00%	24.00%
Other	6.44	6.02	0.42	7.00%	25.00%
Scientific, Therapeutic & Technical	109.31	89.25	20.06	22.00%	43.00%
Total:	595.96	500.35	95.62	19.11%	29.00%

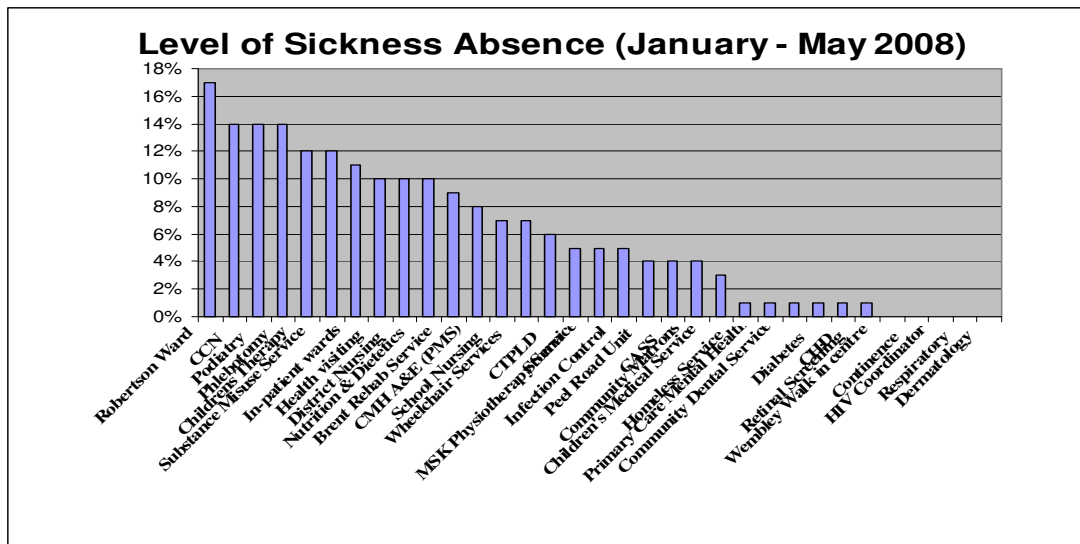
Turnover for all provider staff between July 2007 and July 2008 is 29%. In comparison to the national benchmark of 15% Brent Provider Services turnover rate is high; however staff turnover rates in London are higher than the national average, typically over 20%. Turnover rates by service line are unavailable due to workforce data quality challenges and the rebasing of establishment due to reduction of posts as a result of the financial control measures.

Measured in terms of direct staff per 1,000 resident population, Brent Provider Services staff resources are the lowest of the benchmarking group. Despite this, staff contacts per 1,000 weighted population rank third highest (refer to Figures 3.8). This indicates that, measured in terms of contact per member of staff, the volume of activity per WTE required to meet demand in Brent is higher than average within the benchmarking group.



Another indicator of staff management is sickness absence statistics. From January to May 2009, the overall PCT sickness rate was 5.39% which is 0.89% above the national average (4.5%). **Figure 3.9** shows sickness rates by service and identifies that 50% of services have a sickness rate above 4.5%. These services are, in the main, the larger PCT Provider Services. Active management of sickness absence is now in place within Provider Services which will provide a better indication of the underlying issues of sickness absence.

Figure 3.9: Sickness Absence by Service



3.3 Tangible Assets

In April 2008/09, NHS Brent's fixed assets had a net book value of £52.7m. Of this, £50.2m (or 95%) is accounted for by land and buildings with the remainder being largely equipment.

The PCT is planning to dispose of 5 premises during 2008²⁰, and has two facilities under construction. Of the remaining estate, five buildings are owned by the PCT but used predominantly by independent providers. This leaves 6 buildings that are considered to be core to the community services estate. **Table 3.10** shows the net book values of these core facilities and the split between ownership; PFI and LIFT

Table 3.10 – Value of Owned and Leased Facilities

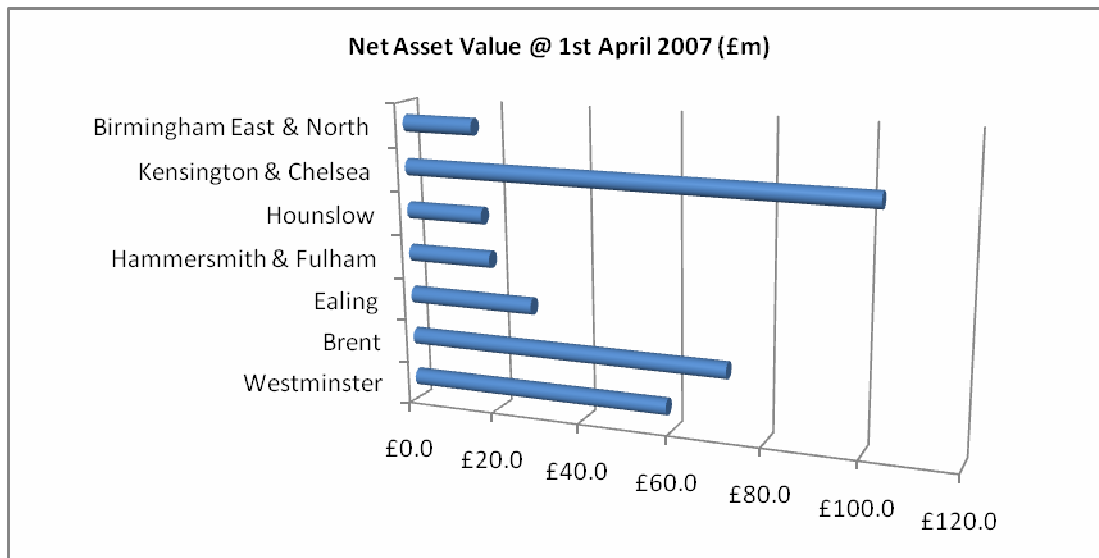
Core Estate	Net Book Value £'000	% Asset Value
Owned		
Wembley Centre for Health & Care	36,209	
Stag Lane Clinic	1,079	
Kilburn Square Clinic	145	
Sub Total	37,433	77.35%
LIFT/PFI		
Sudbury Primary Care Centre	306	
Monks Park Primary Care Centre	152	
Willesden Centre for Health Care	10,502	
Sub Total	10,960	22.65%
Grand Total	48,393	

Figure 3.10 shows that the value of the NHS Brent's asset base in April 2007 (at £70.7m) was one of the highest in the programme. Since this time, the PCT's asset base has been

²⁰ The data in this paragraph and in figure 3.9 are from the Estates Strategy – Phase 1 18 July 2008

reduced to £52.7m. This would still place Brent PCT above average in terms of the value of the community estate for the benchmarking cohort. For example Ealing PCT, which has a similar weighted population, had tangible assets of only £29.8m in April 2007. Given the relative size of the asset base, further work is required to gain a comprehensive picture of the efficiency of the estate either owned or leased by the PCT and the allocation of running, rental and capital charge costs to the Provider Arm services.

Figure 3.10 – Comparison of Provider Services Asset Base in Benchmarking Group



Although somewhat crude, asset turn represents a measure of asset productivity. Asset turn is a calculation of how often over a financial year income covers asset value. Delivery models heavily reliant on either buildings or expensive equipment (such as acute hospitals) would typically have a lower asset turn than those delivered outside hospitals. An asset efficient hospital (that is heavily reliant on facilities to deliver its services) might be expected to turn over its assets once each year (and therefore have an asset turn ratio of 1:1). Brent Provider Services has a comparatively low asset turn (0.9:1). A relatively low asset turn might indicate one (or a combination of) the following:

- The more prominent role that assets play in the portfolio of services delivered. For example, a low incidence of home care requires a relatively high level of infrastructure-dependent services, such as community hospitals, care homes or palliative care units;
- A disproportionately prominent role for owned assets over leased facilities in the asset portfolio;
- Comparatively low asset utilisation (for example, very high levels of vacant or under-used space or equipment);

It is likely that a combination of care setting and low asset utilisation is exerting a strong influence on NHS Brent's asset turn. The PCT has a large and dispersed estate, which is not efficiently utilised. In addition revenue costs represented by maintenance and lease costs are relatively high due to the presence of PFI and LIFT developments. The annual PFI tariff and lease-plus payments are around £4 million for the PCT. The portfolio of services is predominantly delivered in clinic and in-patient settings which is an atypical profile for most community providers within the benchmarking cohort.

Whilst it is difficult to draw firm conclusions from this analysis, the attractiveness to a future provider of long-term proprietorial interests in land and buildings will be significantly influenced by the service portfolio, its reliance upon assets for service quality, current asset utilisation, asset condition and asset fitness for purpose. For PCTs with a bias for leased facilities, their ability either to assign or sub-let these facilities will play a part in determining their approach to the strategic issue of asset management and ownership in the future. Experience in managing and operating assets may also influence whether an area of growth, such as polyclinics, proves to be attractive and/or feasible for Provider Services.

3.4 Summary

Analysis of finance, workforce and activity data enables Brent provider services to gain a good understanding of costs and resource utilisation compared to peers. As with many PCTs, challenges in data availability and quality need to be considered when comparing performance against peers. Considering data across a range of business indicators identifies the need to develop the infrastructure, systems and processes aimed at improving data quality and availability which enable Brent Provider Services to become competitive in the market place. Key headlines from the analysis of finance, activity and workforce information are as follows:

- NHS Brent has been particularly challenged to produce data of sufficient quality to properly inform the analysis required. Activities to improve systems and processes which will ensure accurate data is available will be informed by the findings of the Provider Services Development Programme
- NHS Brent plans to spend £37.08m on community services in 2008/9. Of this amount 97% is with its own community provider. The remaining 3% is spent with its neighboring PCT Providers. NHS Brent is atypical in its over-reliance on its own Provider for the provision of community services.
- In 07/08 Brent Provider Services received 9.1% of the overall PCT budget allocation which is larger than its immediate neighbors, Ealing and Harrow (at 5.9% and 6.2% respectively). The total proportion of spend on other community providers for Ealing and Harrow is not known at present but is worthy of future analysis.
- NHS Brent spends around 35% more per head of 1000 weighted population than Ealing with its Provider Services body. However compared to Ealing, NHS Brent has a slightly smaller population and a similar number of GP's per 1000 population.
- Five services within the Provider portfolio account for over 49% of the total provider expenditure. These are core PCT provider services (District Nursing, Intermediate care, Health Visiting, Peel Road Unit & Community LD & Day Service Teams and

Children's Therapy Teams). A total of 27 other services make up the remainder of the PCT's portfolio which, whilst not unusual for PCTs, does present challenges both for management and operational sustainability of small services. Analysis of the maximum efficient scale of these 27 services is worthy of further work.

- NHS Brent Provider services receive £4.2m income from sources other than NHS Brent Commissioners. Income is received through block contracts for community services provision. Contracts do not provide the detail needed to allocate income to individual service lines. Further work is required to develop more detailed contracts with the identified Non NHS Brent Commissioners
- The analysis of income to Brent Provider Services identifies its own commissioners as the major contributor of income. Whilst this removes some complexity, it also poses challenges to both NHS Brent Provider and Commissioner. For a single borough Provider it presents risks in terms of over reliance on host commissioner and the financial risks associated with the potential loss of contracts if the main commissioner chooses to decommission or market test services. For the commissioner in the demonstration of competence as market shaper in its role as a world class commissioner of health services for the local population.
- Analysis of the provider cost profile shows that the provider budget comprises 51 pay costs, 13% non-pay and 36% indirect costs. This cost profile is significantly different to other PCTs in the PUK Programme, where indirect costs are accounting for between 15% and 30% of the provider total cost base. The high level of indirect costs may reflect both a large and expensive estate. Further work is required on the allocation of indirect costs.
- The large scale of the non-pay (includes direct and indirect non pay costs) results in the average total cost per WTE for Brent Provider Services significantly exceeding the total cost per WTE of peers (at £80,611, some 31% greater than the next highest and more than double the lowest). This presents significant challenges for Brent Provider Services as they take their place in a contestable market of community provision. A significant proportion of these costs are related to the estates costs allocated to Provider Services.
- The cost per contact across NHS Brent Provider services currently sits at £97 which appears high compared to peers. This requires verification following activities aimed at improving data quality and availability are implemented.
- Both pay and non pay expenditure have been reduced significantly over the last 18 months as a consequence of financial control measures. As a result, NHS Brent Provider services pay costs are the lowest within the benchmarking cohort, whereas activity levels per WTE are within the top three PCTs within the benchmarking cohort.
- From January to May 2009, the overall PCT sickness rate was 5.39% which is 0.89% above the national average (4.5%). Sickness rates by service identify that 50% of services have a sickness rate above 4.5%. These services are, in the main, the larger PCT Provider Services. Active management of sickness absence is now in place

within Provider Services which will provide a better indication of the underlying issues of sickness absence.

- Due to the migration of workforce information to the Electronic Staff Record information system, the reconciliation of establishment to staff in post has not been possible by service line and data relating to turnover and vacancy rates by service line are also not available at this time. A workforce data set and reporting mechanisms need to be agreed at both Directorate and Service level to enable the proactive management of staff resource
- The PCT's asset base is comparatively high with a net book value of £52.7m and an asset turn of 0.9:1. In addition the revenue costs of supporting the estate (maintenance, rent and capital charges) are relatively high due to the presence of PFI and LIFT developments - the annual PFI tariff and lease plus payments being around £4 million.

4. Service Line Reviews – Key Findings and Conclusions

In order to make robust decisions about the future nature and shape of its provider services portfolio, NHS Brent has conducted (in conjunction with PUK) the review and assessment of its current portfolio of services. In total 31 individual service line reviews have been undertaken by Service Leads using a common template. Completion of the Reviews were informed by the Service Leads own understanding and experience, discussions with their teams, analysis of service data metrics, market intelligence and comparative analyses of services across PCTs.

For the purpose of this Provider Development Strategy, the 31 services have been grouped and assembled into five aggregated service clusters. These clusters are,

- Children’s Services;
- Learning Disabilities Partnership (integrated with the Local Authority);
- Urgent Care, Rehabilitation and Nursing Services;
- Adult Care Pathways and Outpatient Services;
- Other Services

Table 4.0 lists the services that completed Service Line Reviews²¹.

Table 4.0 – Service Line Reviews Completed

Service Cluster	Service Lines
Children’s Services	Children’s Medical and Children’s Community Nursing Services (includes looked after children and audiology) Children’s Therapy Services School Nursing Health Visiting Homeless Service
Learning Disabilities Partnership	Learning Disabilities (including Peel Road Unit, The Community Team for People with Learning Disabilities (CTPLD), The Community Activity Support Service (CASS))
Adult Inpatients, Community Nursing and Therapies, and Urgent Care	Intermediate Care and Rehabilitation Inpatient Wards Neuro-rehabilitation Inpatient Services Brent Rehabilitation Service (including Falls and Stroke) CMH A&E Front of House Wembley Walk In Centre District Nursing (including Out of Hours) Community Matrons Stoma Continence Nutrition and Dietetics
Adult Care Pathways and Outpatient Services	MSK Physiotherapy Podiatry Phlebotomy Brent and Ealing Wheelchair Services Substance Misuse Service HIV Coordinator Primary Care Mental Health Service Community Dental Service Care pathways: • Diabetes • Cardiology • Dermatology • Respiratory Diabetic Retinal Screening Programme
Other	Infection Control Service Integrated Care Coordination Service (POPP)

²¹ The 31 individual Service Line Reviews completed are available on request from the PWT.

A summary of each service is Located in **Appendix 2**

For the purpose of the review a number of services were grouped into composite service lines. During the process of review, it became apparent that these services were not as closely aligned in focus as first thought. Therefore, a decision was made to apply the service assessment tool to those services [below] separately, hence each will be discussed in their own right in the subsequent sections of this report:

- Children’s Medical Services and Children’s Community Nursing Services
- Learning Disabilities services: Peel Road Unit, CTPLD Team and the CASS Service

Two services were groups as “Other Services” for the purpose of describing service clusters. The rationale for this is identified below:

- Infection Control Service – The service is a support service to all other services within the portfolio and is not patient facing
- Brent Integrated Care Coordination Service (POPP) - The initial review of this service identified that it was a short term funded project which was subject to formal commissioner evaluation and was therefore excluded from the programme

Table 4.1 sets out the proportion of the Provider Services’ business to which each of the five service clusters contribute.

Table 4.1 – Service Groupings for NHS Brent Provider Services

Service Cluster	Staff WTE	%	2008/09 Budget £’000	%
Children’s Services	154.04	29.22	£10,664	26.73
Learning Disabilities Partnership	48.31	9.16	£3,644	9.14
Adult Inpatients, Community Nursing and Therapies, and Urgent Care	219.45	41.62	£16,105	40.38
Adult Care Pathways and Outpatient Services	97.04	18.40	£8,634	21.65
Other	8.40	1.59	£839	2.10
Total	527.24	100.00	£39,886	100.00

Note: Budget figures include indirect cost and on-costs.

One of the main purposes of conducting the Service Line Reviews is to allow Brent’s Provider Services to draw some conclusions about the future configuration of its business, especially in the light of the challenges described earlier in this document. Such conclusions will inform the nature of agreements regarding the development and future positioning of services with Commissioners. Conclusions can range from:

- **Conclusion 1** - Recognise the challenges inherent in running, developing or strengthening a service, adopt the service as part of NHS Brent Provider Services in the long term and resolve to put in place appropriate solutions to those challenges; or

- **Conclusion 2** - Adopt the service as part of Provider Services in the short to medium term, but, in doing so, both NHS Brent and Provider Services commit to work together to address the challenges and to share risks in doing so. Equally, both NHS Brent and Brent Provider Services will, after an agreed period, formally re-assess whether significant headway has been made to resolve the challenges; or
- **Conclusion 3** - Choose not to introduce the service as part of the Provider Services portfolio.

4.1 Overview of Service Line Review Process

The Service Line Review process for individual services has used the following six-point framework of analysis:

- **Fitness for purpose** - testing commissioner support for the service, cost and quality, patient access and productivity of resources deployed;
- **Strategic fit of services** - examining inter-dependencies between services and the degree to which they contribute to the PCT meeting its own key priorities, as set out principally in the Commissioning Strategy Plan 2007-20;
- **Competitive intensity** - investigating the likelihood and impact of competition on the service, both from within and outside the NHS;
- **Risk** - assessing the level of clinical, operational and/or financial risk faced by the service, notably if there is a realistic prospect of market testing by PCT commissioners or PbC clusters;
- **Management challenge** - examining the scale of management effort required to deliver the service to its best potential;
- **Overall attractiveness** – examining the appeal of the individual service to a future autonomous provider organisation, based on an aggregation of the above analysis.

Based upon the findings of the individual Service Line Reviews conducted by Service Leads and analysis through the subsequent “confirm and challenge” process, the PWT is able to make recommendations about service futures and, in particular, recommend whether an individual service line should be categorised as:

- i. **Category A** – be retained in the long term and developed by Provider Services as part of its core service portfolio.
- ii. **Category B** – be subject to a focused period of redesign and then re-assessed by NHS Brent Commissioner and Provider Services within an agreed period to consider future long term inclusion within the provider portfolio
- iii. **Category C** – to be considered for transfer to other providers or parts of the PCT.
- iv. **Category D** – should be discontinued and/or the PCT’s requirements substantially re-framed so that a significantly different service model results.

4.2 Limitations of the service assessments

The service review and assessment process requires examination of a range of information which provides a detailed description of services. There is a recognition that this level of scrutiny has not previously been expected, hence the infrastructure and systems to support the provision of information are either not in place or in their early stages of development and implementation. Taking this into account, it is important to highlight some of the limitations of the service assessments and the future implications relating to these issues before discussing the summary findings. Such limitations include:

- **Harnessing engagement and ownership of the service review and assessment process** - the service review and assessment process requires service leads to provide a detailed and honest reflection of their service. The impact of the Turnaround programme and changes to senior leadership within the Directorate led Service Leads to lack confidence that the process would be fair, significantly robust and patient focused. This resulted in delays in the early stages of the programme and influenced the initial quality of service reviews. However full engagement of service leads in the process of review and the open and honest management style of the current directorate senior management team has led to full engagement and ownership of Service Leads in decisions regarding the future positioning of their individual service lines. It is recognised that the service review and assessment process is the start of a journey of service transformation. It is recommended that a staff communications and engagement strategy is developed to ensure the full engagement of staff in future service changes.
- **Quality of service reviews and assessments** - the Service Line Review process requires a service review template to be completed by the Service Lead with support from the Project Manager and Assistant Directors. The quality of output was limited; in the main due to time pressures faced by Service Leads and for some services, a change of service lead during the review process as a result of the Directorate management restructure. The impact of low levels of investment in skills development over a number of years, particularly across the middle management tier, contributed to the abilities of a number of service leads to provide a well thought through and evidenced review of their service. A blend of 1:1 support for Service Leads and the Confirm and Challenge process enabled the robust assessment of services. Evidence tells us that the skills and competencies of middle management have a direct impact on the safe and effective delivery of patient care. It is recommended that a management development programme is put in place for Service Leads
- **Activity data is incomplete and not felt to be wholly accurate.** NHS Brent is in the process of implementing a new patient information system (RIO) across all service lines. Whilst some are using the new system successfully (e.g. Care Pathways) others have found it not meeting their needs at present (e.g. District Nursing) and are in the process of resolving issues identified. Some services continue to use the previous patient information system (CIS), some collect data at service level only and others have no service data available. For a number of services there are also issues with the quality of electronic patient data which is felt not to capture

an accurate record of patient interventions. Informatics support to the Directorate is limited and requires review to ensure that the information needs of Provider Services are met and a service performance and development culture at service level is embedded as a core characteristic of NHS Brent Provider Services.

Data capture and utilisation to inform future decisions about the nature, shape and performance of the Provider Services, is key to the provider becoming a world class provider of choice. The service review process has raised awareness to the value of information needed to define a successful business and has led to an increased understanding amongst service leads of the need to review processes for data capture and utilisation within individual services and the provider unit as a whole. Development of data systems and processes will need to be linked to the RIO implementation project which is already in operation within the PCT.

- **Ability to express outcomes and measure performance**— defining outcomes and associated metrics is challenging for both commissioners and providers alike. Lack of a robust framework and a common information currency hampers the ability to assess the performance of services against commissioner requirements. Where services are clearly aligned with NSF standards, such as the Pathway and Therapy services, the expression and measurements of direct performance of the services is more mature. Having the ability to define and express outcomes and associated metrics will enable provider services to respond effectively to tenders, calculate costs and associated benefits and measure effectiveness.
- **Customer feedback about the services** – user involvement in service development and feedback on service performance has not been a built-in feature of ongoing service delivery for most services. Six services have carried out a patient satisfaction survey in the last 15 months but these were developed within individual services with no uniformity in the types of questions asked or what is done with the results. Several services have started to actively involve users in service development and 2 services have a user group in place (Continence and HIV). Overall, though, there has been little consistency in the way services seek feedback from patients and customers of the services (such as GPs). However, a number of services are now taking a more focused approach, and patient surveys are planned over the next few months. Public engagement is a key competence of world class commissioners and providers. NHS Brent Provider Services will want to review its practices relating to patient and public engagement in line with the PCT commissioning developments, before formulating plans to strengthen patient and public involvement within individual services and the Provider as a whole.

Seeking the views of GPs about the quality and nature of services has not been part of normal practice within services. As part of the service review process GPs' views have been sought through a GP survey. The response rate was low and therefore the findings are not statistically robust, however this exercise has provided some information on some important stakeholder views and has provided an opportunity to test methods of seeking the views of individual GP's (a summary of findings from the survey is located in **Appendix 3.**) Involvement from PbC groups in providing a commissioner view on the provision of community services has been limited.

However, the establishment of direct relationships between Provider Services and Practice Based Commissioners are starting to develop.

Given the increasingly prominent role of both PbCs and patients in future commissioning decisions, it is critical that Brent Provider Services continues to develop methods to systematically obtain an accurate and up-to-date picture of the priorities, intentions and plans of these two constituencies.

- **Cost analysis** – interpretation of the level of financial efficiency has been based on the services ability to articulate cost: and to count relevant activity. This has been problematic for the majority of the services. Services have expressed a desire to develop systems aimed at helping them first to measure and then to evidence cost benefit to their customers.

4.3 Service Assessment Findings

4.3.1 Fitness for Purpose

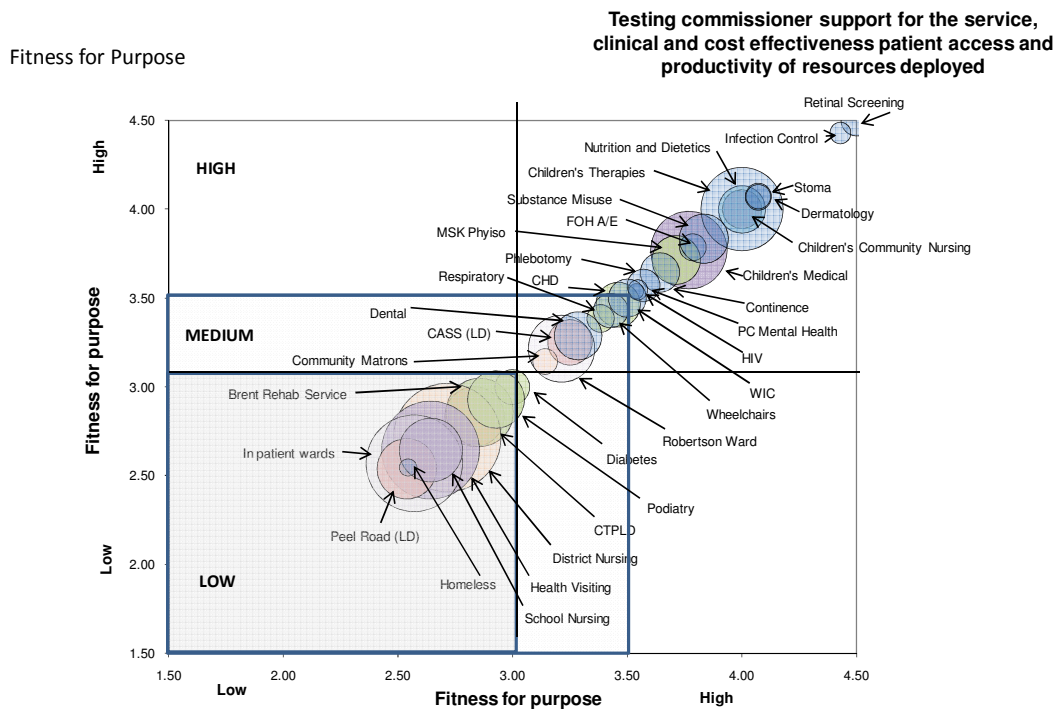
The primary determinants of fitness for purpose are:

- The extent to which the service is delivering care according to clinical need and achieving the requisite clinical and performance standards;
- Whether the service has reached the minimum efficient scale to be run effectively and efficiently;
- How cost effective the service is compared to competitors;
- The level of commissioner support enjoyed by the service;
- Patient access to and experience of the service; and
- How productively the service employs its resources, both human and physical.

Scores for these criteria were derived from the finalised Service Line Reviews in discussion with the Assistant Directors, and then moderated by the PWT through review of evidence presented by Service Leads as part of the Service Line Review process. The scoring was done on a 5 point scale, and so an average score of less than 3.0 was judged low. A score between 3.0 to 3.5 was viewed as moderately Fit for Purpose and higher than 3.5 was considered high. The size of the bubble represents the size of the service in terms of income. **Figure 4.1** shows how Brent Provider Services service portfolio is assessed and scored on Fitness for Purpose as defined above²².

²² In **Figure 4.1**, the Fitness For Purpose scale is repeated for the x-axis and the y-axis, essentially allowing variability only along a single plane, from the origin towards the top right hand corner. For subsequent graphs, Fitness for Purpose remains constant along the y-axis.

Figure 4.1 Fitness for purpose assessment



Brent PCT : PSDP - Service Assessments July 2008

1

It should be noted that the assessment of Fitness for Purpose is based on a balance of strengths and weaknesses across a range of criteria. The pattern of individual services within the service portfolio assessed against fitness for purpose shows a spread of service along the scale of low to high fitness for purpose. Children's services and the smaller more discreet services within the portfolio are assessed as having a relatively high level of fitness for purpose whereas the large and typically core community provider services, district nursing, health visiting, and school nursing are assessed as having low fitness for purpose. Further independent scrutiny of these core services and triangulation of clinical and operation risks, complaints and reported incidents has validated this assessment. It is of concern that all core services are assessed to be of low Fitness for Purpose as this presents significant challenges in developing these services to enable them to deliver safe and effective care to the local population. In defining the future nature and shape of Provider Services going forward, NHS Brent Provider Services may choose to focus on delivering core services until they are significantly Fit for Purpose before extending out from the Core. Three services, Walk-in-centre, Front of House and the Pathway Services, have been assessed as having a medium level of Fitness for Purpose, yet these services are currently under review by Commissioners due to their in-ability to deliver against commissioning requirements. It is felt that the balance of risks posed by these services, their ability to demonstrate strategic fit with PCT objectives and their ability to provide good access has counterbalanced commissioners concerns regarding service performance, hence their presentation as being moderately Fit for Purpose.

Tables 4.2 to 4.4 (below) describe the positive and negative features of services within the Provider portfolio which provide the rationale for their positioning along the scale of fitness for purpose.

High Fitness for Purpose Service Lines

Services positioned in the “High Fitness for Purpose” quadrant are at the top right of the graph. **Table 4.2** summarises the key features of these services (**Appendix 2** presents individual service assessment outcomes against the six points of analysis):

Table 4.2 - High Fitness for Purpose

Fitness for Purpose			
Service		Positive Features	Negative Features
Children's Services			
1	Children's Medical Service	<ul style="list-style-type: none"> Highly productive and motivated team Good commissioner support with little interest in market testing Service achieving quality standards with rising demand on the service 	<ul style="list-style-type: none"> Audiology service subject to review due to retirement of consultant and possible duplication of service provision with acute trust Lack of robust data hampers ability to evidence achievement of health outcomes
2	Children's Community Nursing	<ul style="list-style-type: none"> Well managed service achieving high levels of productivity Targets people who require home based care and demonstrates (anecdotal) evidence of admission avoidance High level of patient satisfaction and access to service High level of commissioner support 	<ul style="list-style-type: none"> Capacity and demand modeling not in place which prevents ability to quantify increased demand resulting from growth and changing profile of Brent's population Lack of robust data hampers ability to evidence achievement of health outcomes Service coverage is predominately for children under the care of NWLHT. Children who receive care in other acute hospitals are not known to the service
3	Children's Therapies	<ul style="list-style-type: none"> Able to demonstrate achievement of outcomes and standards Demonstrates high level of productivity High level of commissioners support for this service particularly in relation to the service redefinition following Turnaround 	<ul style="list-style-type: none"> Some recruitment challenges with shortages of specialist staff Prioritised waiting list in place but this would benefit from further development of waiting list management
Adult Inpatients, Community Nursing and Therapies, and Urgent Care			
1	Nutrition and Dietetics	<ul style="list-style-type: none"> Able to demonstrate achievement of health outcomes Targets key health priorities Patient surveys indicate high levels of satisfaction 	<ul style="list-style-type: none"> High breadth service which requires spread of resource of small team which may lead to skills dilution Although access is good in a number of sites, there are some gaps in provision and long waits for diabetes patients.
2	CMH A&E Front of House	<ul style="list-style-type: none"> Motivated staff Based in a central location with good public transport infrastructure to facilitate accessibility Patient experience reported to be good Contributes to PCT 4 hour A/E waiting time target 	<ul style="list-style-type: none"> Patient triage by acute trust affects demand and appropriateness of referrals which contributes to low staff productivity compared to alternative providers Service under commissioner review due to inability to meet contractual requirements (performance requirements are unclear and require confirmation)
3	Continence	<ul style="list-style-type: none"> Service achieving national standards Patient feedback is good and users involved in service development Commissioners want to expand service to cover nursing homes and are looking to the existing provider 	<ul style="list-style-type: none"> Lack of robust data hampers ability to evidence achievement of health outcomes and reporting performance Cost benefit analysis not evidenced Lone practitioner with no cover arrangements Currently service running at a minimum level but planning to recruit staff
4	Stoma	<ul style="list-style-type: none"> Strong service focus delivered by highly skilled and dedicated practitioners Responsive service with no waits Positive patient feedback Products secured through external funding from product suppliers which contains 	<ul style="list-style-type: none"> Lack of a patient information system impacts on ability to measure cost benefit and performance. Need to provide data to commissioners to evidence admission avoidance Service continuity reliant of two specialist

		supplies and consumable expenditure	and dedicated practitioners. Service coverage at risk in times of absence
Adult Care Pathways and Outpatient Services			
1	Diabetic Retinal Screening Programme	<ul style="list-style-type: none"> Recognised by the national diabetes network as a national benchmark for other services Demonstrably achieving the majority of its national standards Staff productivity is high Good commissioner support 	<ul style="list-style-type: none"> DNA rates for screening clinics are high, although the service has reduced this over the last year and are developing further strategies. Service relies on reception support services provided by NWLH – cost of this support is not included in calculation of service costs
2	Dermatology Care Pathway	<ul style="list-style-type: none"> Achieving 30% reduction in dermatology outpatient attendances at acute trusts Good patient satisfaction and low waiting times Some evidence to indicate that service cost is less than cost of an outpatient appointment (more detailed analysis to validate is required) 	<ul style="list-style-type: none"> Skill mix over-reliant on medical input – skill mix review required. Cost benefit analysis not robustly evidenced
3	MSK Physiotherapy	<ul style="list-style-type: none"> Service costs have been reduced through reconfiguration Positive informal patient feedback and patient survey planned Provides care from 2 locations and waiting times are reducing with return to a fully established team 	<ul style="list-style-type: none"> Data not sufficiently robust to support understanding of demand/capacity and utilisation rates, case mix and cost per case Challenges in recruiting senior staff Service name implies that this is an MSK service when the service model is typical of a community physiotherapy service
4	Substance Misuse Service	<ul style="list-style-type: none"> Able to demonstrate evidence of meeting most targets for treatment provision Positive commissioner support but would like to change the model of care 	<ul style="list-style-type: none"> Delivering unfunded activities and not capturing frequency and outcomes of this work High sickness felt to be linked to high caseloads and stress levels
5	Phlebotomy	<ul style="list-style-type: none"> Service meets objectives and has exceeded service requirement by 15,000 contacts last year Provides a service across 5 sites and provides a small domiciliary service to housebound patients High demand 	<ul style="list-style-type: none"> Was set up as a pilot in 2005 and not formally moved from pilot status May be subject to commissioner review Long waiting times for walk in patients Increase in complaints from people requiring fasting blood sugars due to inaccessibility of timely investigation
6	Primary Care Mental Health Service	<ul style="list-style-type: none"> Well functioning team who have developed service into a CBT based service. Positive feedback from clients Self help interventions offered to those on waiting list Well respected service 	<ul style="list-style-type: none"> Commissioning currently redesigning psychological therapies and had not featured this service in those developments Lack of admin support impacts on clinical time Activity reporting undeveloped Coverage limited to a few GP practices with access to wider population address via small clinic provision
7	HIV Coordinator	<ul style="list-style-type: none"> Dedicated sole practitioner with good service outcomes High level of patient satisfaction and user group in place Multiple points of referral 	<ul style="list-style-type: none"> Commissioners supportive of the service but would like to see this developed into an integrated health and social care team model Patient access limited at times of annual leave and sickness
Other			
1	Infection Control	<ul style="list-style-type: none"> Able to demonstrate evidence of achieving national and local standards Highly productive service with larger number of projects undertaken compared anecdotally to other PCTs Good commissioner support Good access to service by PCT staff and independent contractors 	<ul style="list-style-type: none"> Lack of clarity as to the scope of the service and who provides patient facing infection prevention support Service model based on infection control verses infection prevention

Moderate (or Unclear) Fitness for Purpose Service Lines

A number of services were clustered towards the middle of the Fitness for Purpose scale. The two main reasons for this were:

- i. Some services had highly Fit for Purpose elements, but these were offset by other elements which were less so; and/or
- ii. Some services were simply very hard to judge, mainly due to lack of evidence one way or the other (see **Table 4.3**).

Table 4.3 - Moderate (or Unclear) Fitness for Purpose

Fitness for Purpose			
Service	Positive Features	Negative Features	
Learning Disabilities Partnership			
1	CASS	<ul style="list-style-type: none"> • Provides a person centered model of care • Held in high regard by patients and carers 	<ul style="list-style-type: none"> • Challenges around demonstrating service outcomes and quality • Expensive service due to skill mix • Provides social care verses health care hence low level of health commissioner support
Adult Inpatients, Community Nursing and Therapies, and Urgent Care			
1	Community Matrons	<ul style="list-style-type: none"> • Evidence suggests service is meeting some of its targets • Staff productivity in line with other PCTs • Patient surveys indicate that patients and carers think highly of the service 	<ul style="list-style-type: none"> • Pilot project with no immediate plans to mainstream • Lack of understanding regarding capacity, demand and case mix • Cost benefit analysis has not been undertaken • Lack of structured mentorship and support to master advanced nursing skills
2	Neuro-rehabilitation inpatient service	<ul style="list-style-type: none"> • Highly committed Consultant with strong clinical leadership • High bed occupancy and demonstrable reduction in length of stay • Clear approach to measuring clinical outcomes in place 	<ul style="list-style-type: none"> • Challenges around demand and capacity with waiting times up to 8 weeks • Resources limited with single handed consultant with no formal cover arrangements • High levels of staff sickness absence • All the rehabilitation services face recruitment difficulties nationally. No clear recruitment and retention plan in place
3	Wembley Walk In Centre	<ul style="list-style-type: none"> • Is able to demonstrate effectiveness in the services contribution to reducing inappropriate A&E Attendances and primary care 24/48 hour target • Popular service with patients with good access 	<ul style="list-style-type: none"> • Commissioners are considering other options such as linking to a GP-led health centre • Provider is currently managing the service for commissioners and has little management control over the service
Adult Care Pathways and Outpatient Services			
1	Community Dental Service	<ul style="list-style-type: none"> • Commissioners positive about how far the service has traveled since desegregation in April 2007 • Provides a service which bridges a key commissioning need • Able to demonstrate achievement of quality standards • Brides a gap in local dental provision for people with complex health needs 	<ul style="list-style-type: none"> • Service challenged by long waiting lists and inefficiency in the way resources are deployed • Commissioner concern expressed over patient access • Lack of Dental clinical lead to assure clinical effectiveness • Electronic patient data systems not in place

2	Brent and Ealing Wheelchair Services	<ul style="list-style-type: none"> • Able to demonstrate achievement of most standards • Anecdotal evidence of prevention of delayed discharge and prevention of pressure sores • High patient satisfaction and improved waiting times since last year 	<ul style="list-style-type: none"> • Challenged by high sickness levels and recruitment difficulties • Currently do not have scale to operate efficiently
3	Care Pathways – Diabetes, Cardiology Respiratory	<ul style="list-style-type: none"> • Passionate and committed to long term condition management in the community • Targets key health priorities and meets NSF targets • Service access is good 	<ul style="list-style-type: none"> • Robust performance framework not in place to show evidence of stated outputs, outcomes and cost benefit • Challenges around understanding which elements of the service are provider or commissioning functions • Limited GP engagement for some elements of these services • Mixed level of commissioner support for these services due to confusion over what the service delivers – subject to commissioner review

Falling Short of Fitness for Purpose

A small number of services face significant challenges when assessed against the Fitness for Purpose criteria. These challenges include: lack of scale, lack of evidence to demonstrate achievement of national and local priorities and/or cost effectiveness and cost benefit, and immaturity of service model compared to neighbors. **Table 4.4** identifies the positive and negative features of those services. It is notable that typically core community provider services have been assessed as falling short of fitness for purpose

Table 4.4 – Falling Short of Fitness for Intended Purpose

Fitness for Purpose			
Service		Positive Features	Negative Features
<i>Children's Services</i>			
1	Health Visiting	<ul style="list-style-type: none"> • Large staff group which are commissioned to provider services which are strategically aligned to PCT priorities and mandatory requirements • Informal user feedback is positive • Strong professional clinical leadership 	<ul style="list-style-type: none"> • Commissioners have concerns about the ability of the service to deliver against the full specification • Data quality requires development to facilitate measurement of outcomes • Concerns raised regarding the clinical effectiveness and ability of the service to safeguard children
2	School Nurses	<ul style="list-style-type: none"> • Motivated team with good levels of productivity • Dedicated special schools SN team 	<ul style="list-style-type: none"> • Lack of robust capacity and demand modeling in place • Commissioners have concerns about the ability of the service to deliver against the full specification • Challenges around recruitment with an aging workforce within the team and national shortages. • Service model not in line with national best practice • Special school nursing service is more aligned to the children's nursing service than the school nursing service • PbC challenges that geographical delivery model is not meeting their needs
3	Homeless Service	<ul style="list-style-type: none"> • Highly regarded autonomous team with specialist expertise • Team in place for 14 years and well known to service users 	<ul style="list-style-type: none"> • Poorly resourced service with minimal clinical staffing, working mainly in isolation. High level of operational risk • Challenges around evidencing level of performance due to lack of outcomes and activity data • Low commissioner support for the

			current model of care with potential that this service is duplicating service commissioned from other providers
Learning Disabilities Partnership			
1	Peel Road Unit	<ul style="list-style-type: none"> • Has provided a long term place of residence for a small client base • Strong clinical leadership now in place 	<ul style="list-style-type: none"> • Service model not in line with national best practice • Low level of clinical effectiveness and safety with associated high level of clinical risk and operational risk • High Commissioner concerns expressed
2	CTPLD Team	<ul style="list-style-type: none"> • Informal feedback indicates that service users and families hold the service in high regard • Service model provides integrated health and social care to a vulnerable population • Strong clinical leadership now in place 	<ul style="list-style-type: none"> • Service model looks expensive and requires a review of skill mix • Unable to express clinical outcomes and systems to measure performance are not in place. • Commissioner concerns expressed
Adult Inpatients, Community Nursing and Therapies, and Urgent Care			
1	Brent Rehabilitation Service	<ul style="list-style-type: none"> • Committed team • Exhibits some characteristics of a Rapid Response Team • Systems in place to measure specific clinical outcomes 	<ul style="list-style-type: none"> • Lack of evidence around admission avoidance, prevention of falls and prevention of delayed discharge • Commissioner concerns regarding patient access due to long waiting times which influences delayed discharge from in-patient units • Recruitment challenges with no clear recruitment strategy in place
2	Intermediate Care and Rehabilitation Inpatient Wards	<ul style="list-style-type: none"> • Excellent practice around infection control • Based in a community setting • Staff competence in interventional nursing skills reported to be effective 	<ul style="list-style-type: none"> • High levels of sickness absence has an impact on service quality • Lack of evidence that service provides clinically effective care • Rehabilitation aspect of the care model is only available during day time working hours • Low commissioner support for the current model of provision • Access good but low occupancy levels
3	District Nursing	<ul style="list-style-type: none"> • Committed staff • Positive patient feedback • Experienced team of DN's 	<ul style="list-style-type: none"> • High levels of sickness absence which impacts on performance and service quality • Concerns regarding the ability of the service to address clinical quality, safety and capacity issues • Lack of admin support hampers quality of patient activity information. • No clear definition of service outcomes and associated measures • PbC challenges that geographical delivery model is not meeting their needs
Adult Care Pathways and Outpatient Services			
1	Podiatry	<ul style="list-style-type: none"> • Committed staff working with high caseloads • Good clinical outcomes reported anecdotally • Service focus and scope has been developed in line with reductions in resource 	<ul style="list-style-type: none"> • High level of complaints, mainly about reduction in access to nail cutting service. • No clear definition of service outcomes and associated measures • Lack of admin support • Under-resourced equipment maintenance programme • Service access criteria felt to be too rigid

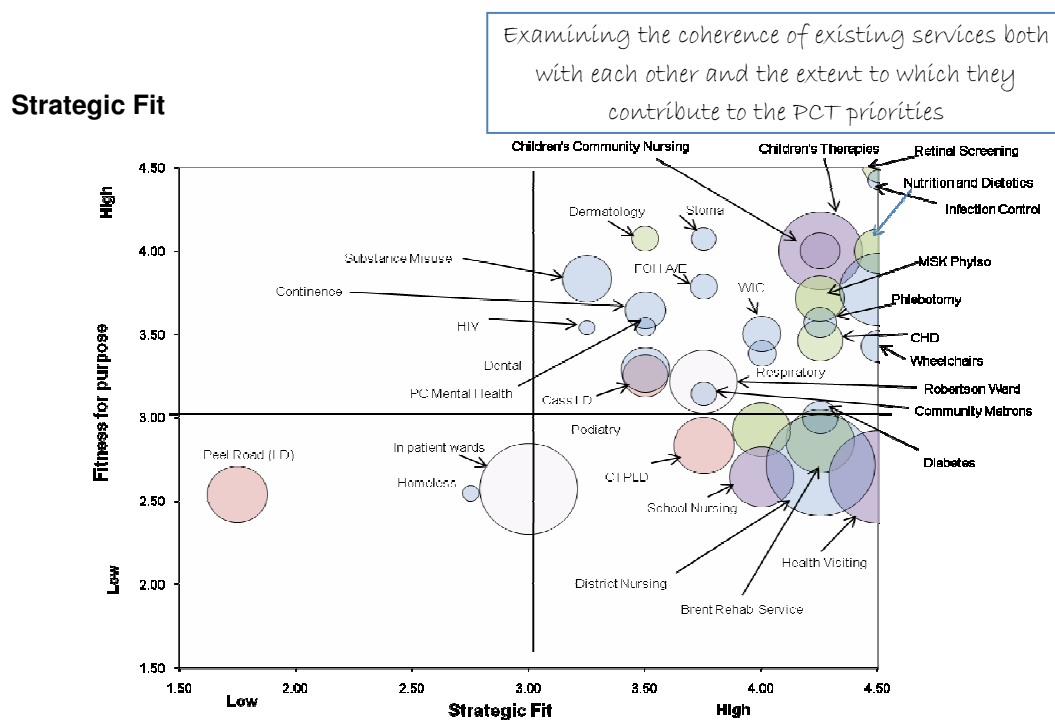
4.3.2 Strategic Fit

Strategic fit is assessed by considering:

- How far commissioners view the service as important in meeting commissioning priorities, as set out in their 2007 Commissioning Strategy, other declarations of commissioner intent and the services contribution to relevant national and local targets and local health need
- How far the service makes a significant contribution to the quality of other services being delivered by Brent Provider Services
- Is central to the delivery of services by strategically important external partners, such as the Local Authority
- Whether or not other service providers are choosing to withdraw from this type of service

Figure 4.2 shows how Brent Provider Services service portfolio performs when Fitness for Purpose is mapped against Strategic Fit. Services which have a high Strategic Fit but low to medium Fitness for Purpose might be prioritised for development in recognition of the potential contribution they make to delivering national and local priorities. Services with a low Strategic Fit and low Fitness for Purpose might be considered for decommissioning as they add little value (in their current form) to delivery of national and local priorities.

Figure 4.2: Strategic Fit Assessment



The majority of Brent Provider Services demonstrate a high level of Strategic Fit with the strategic priorities of the PCT. The services have been able to clearly articulate their contribution to PCT objectives. However, there are a number of these services that are also assessed as having a low/medium Fitness for Purpose and some service which are of high Fitness for Purpose and high Strategic Fit but are worthy of mention. These services include:

Services with a high Strategic Fit and medium Fitness for Purpose

- **Wembley Walk In Centre** was developed to support the delivery of access targets within Primary Care. The model of care is atypical of Walk-in-Centre models nationally as is more aligned to GP access services. The achievement of high Strategic Fit is associated with the potential for this service to prevent unnecessary A/E attendance and reduce health inequalities.
- **Community Matron Service** was established as a pilot and as yet, decisions regarding future provision of case management for people with complex long term conditions has not been considered. The achievement of high Strategic Fit is associated national requirement to have a number of Community Matrons in post, the potential for this service to prevent unnecessary A/E attendance and admission to hospital and strategic coherence with other services with the Provider portfolio
- **Care Pathway Services** are under formal commissioner review mainly due to the lack of clarity regarding the focus of these services and their relative performance. The achievement of high Strategic Fit is associated the potential for this service to prevent unnecessary out-patient attendance and the provision of care closer to home
- **Wheelchair service:** The achievement of high level of Strategic Fit is associated with the potential for this service to reduce long term reliance on health care resources, provider care closer to home and provide care to people the long term conditions. This is associated with the level of strategic coherence this service has with others within the Provider portfolio

Services with medium Strategic Fit and medium Fitness for Purpose

- **CASS** provides activity based support for people with profound learning disabilities in community settings. The service is held in high regard, however the model of provision has a predominant social care focus and nationally the lead responsibility for commissioning care for this client group is the Local Authority. The achievement of medium Strategic Fit is associated with strong alignment with social care priorities balanced by the inter-relationship between this service and the two other PCT Learning Disabilities services
- **Dental Service** :The achievement of medium Strategic Fit is associated with low level of strategic coherence with other services within the Provider Services portfolio. This is balanced by the services potential to reduce health inequalities and address the dental requirements of people with complex dental health needs.

- **Podiatry** : the achievement of medium Strategic Fit is associated with low level of strategic coherence with other services within the Provider Services Portfolio. This is balanced by the high level of commissioner support for this service and its ability to provide essential foot care service to people with diabetes
- **Robertson Ward** : the achievement of medium level of Strategic Fit is associated with the potential for this service to reduce long term reliance on health care resources, provide care closer to home, reduced length of stay and hospital admission. This is balanced by the level of strategic coherence this service has with others within the Provider portfolio
- **PC Mental Health** : The achievement of medium level of Strategic Fit is associated with the potential for this service to reduce long term reliance on health care resources, provide care closer to home and deliver care in line with national requirements for people with low level mental health needs. This is balanced by the level of strategic coherence this service has with others within the Provider portfolio
- **HIV** : The achievement of medium level of Strategic Fit is associated with the potential for this service to reduce long term reliance on health care resources, provide care closer to home, provide care to people with long term conditions, address health inequalities and reduce the spread of infection. This is balanced by the level of strategic coherence this service has with others within the Provider portfolio
- **Phlebotomy** : The achievement of medium level of Strategic Fit is associated with the potential for this service to provide care closer to home and essential and timely diagnostic services to the local population. This is balanced by the level of strategic coherence this service has with others within the Provider portfolio.

Services with a low Strategic Fit and low Fitness for Purpose

- **Peel Road Unit** provides residential care to a small cohort of people with profound Learning Disabilities who have both social and health care requirements. The service is jointly commissioned by the PCT and Local Authority. It is recognised that the current service model is not in line with national policy and best practice in relation to the care needs of its residents. The predominant needs of people within the unit are those of being housed in a safe environment which enables the residents to achieve their maximum potential: the main focus being their social care requirements. The core purpose of the PCT (at this time) is to commission and provide health care; hence the low level of Strategic Fit between the PCT priorities and those of Peel Road
- **Homeless Service** has been in existence for a number of years but has not been aligned to the commissioning of alternative primary care service provision. The current PCT homeless service is delivered by 2 individuals who have developed the service without a clear direction of travel. Access to the service is challenged by service size and the contracted working patterns of the staffing resource. There is no evidence that demonstrates the need for the interventions undertaken by this team to be delivered by health care professionals within Provider Services and there is little coherence between this service and others within the Provider portfolio. However, there is felt to be a

stronger coherence between this service and those of primary care and/or social care than with those within the PCT provider portfolio

- **In-Patient wards** provide step-down facilities and have restricted admission criteria. The model of care facilitates the reduction of delayed discharge for a particular client group, however potential opportunities to provide in-patient intermediate care have not been optimised. This is balanced by the potential for this service to reduce length of stay, reduce delayed discharge and provide care closer to home for the population it services

Services with high Strategic fit but worthy of mention

- **Substance Misuse Service** – The achievement of high level of strategic fit is associated with the potential for this service to meet the health needs of a significant population group. Commissioners are very supportive of this service and view it as one that provides a range of high quality clinical interventions through a number of committed staff. The service is currently in the consultation phase of a planned relocation of the service to the local acute mental health trust as it is felt there is a low level of strategic coherence with other services within the Provider portfolio.
- **CMH A&E Front of House** - The achievement of high strategic fit is associated with the potential for this service to prevent unnecessary A/E attendance and reduce health inequalities. There is little strategic coherence between this service and others within the Provider portfolio. This service is currently subject to formal commissioner review due to Brent Provider Services inability to meet required service performance.

In considering Strategic Fit with local and national priorities, Brent Provider Services is able to demonstrate that services are developing in line with the national policy direction although many experience challenges in flexing resources to meet changing needs due to low levels of investment in staff development and the previous low level of management resource to support service change.

When looking at the portfolio across the health care continuum (from primary prevention to end of life care) it is apparent that Provider Services predominantly delivers care in clinic settings and to a lesser extent, in people's homes and in so doing, offers services which focus on immediate intervention and continuing care (**see Figure 4.3**). This profile is different to Peers who provide care predominantly in home settings. The differences in Brent's Provider services care delivery profile may be symptomatic of the need to provide a significant number of contacts with a low staff resource, or an atypical service model.

Figure 4.3: Mapping care delivery

Care Setting	Health Care Continuum				
	Primary Prevention	Prevention: People at High Risk	Immediate Intervention	Continuing Care	End of Life Care
Own Home	••	••••••••	•••••••• ••••••••	•••••••• ••	••••
Meeting Place	••••••••	••••••••	•••••••• ••••••••	•	
Clinic	••••••••••	•••••••• ••••••••	•••••••• •••••••• •••••••• ••••••••		
Bedded Unit			••••••••	•	
Acute		•	••••••••		
Hospice					•

• Secondary Service focus • Primary Service focus

Although a few services focus on the early diagnosis of disease such as the Phlebotomy service, some aspects of the pathway services, Children’s Medical services, the Retinal Screening Service and Dental Service, the majority of services focus on preventing the escalation of disease.

Brent’s relatively young population, rising birth rate and high numbers of transient people has led to an increase in the numbers of children born with disabilities. In addition to children’s services, the Community Dental, Wheelchair, Nutrition and Dietetics and Continence services all provide interventions to children with disabilities. Diabetes and CHD are key health priorities within Brent; a number of services contribute to the delivery of care to people with these (and other) long term conditions. Stroke care, which is a national and local priority, is provided by district nursing services, the Inpatient wards, rehabilitation services, Continence, Nutrition and Dietetics, and the Wheelchair Service.

Most services provide mobile care delivery that reaches to the centre of an individual’s living environment. Without this, many of the most vulnerable and needy residents would be unable to receive the healthcare they require. All nursing and therapy services provide domiciliary care.

The Walk-in- Centre which was established to address capacity gaps in Primary Care is positioned in a convenient and accessible site at the heart of that community. Similarly, most services which provide clinic based care, do so from various locations across Brent to ensure that services are accessible and delivered as close to home as possible.

Figure 4.4 maps services contribution to preventing escalation of the key health priorities of the local population.

Figure 4.4 services contribution preventing escalation of the key health priorities of the local population.

	Increasing birth rate	Diabetes	CHD	Cancer	Chronic Health Conditions - High level of Deprivation	Stroke	TB and other infectious diseases	Preventing Unplanned Admissions / OP Attendance
Children's Medical	√√							<input type="checkbox"/>
Children's Community Nursing	√√							<input type="checkbox"/>
Children's Therapy Services	√√							
School Nursing	√√√						√√	
Health Visiting	√√√						√√	
Homeless Service	√√	√√	√√		√√		√√	<input type="checkbox"/>
Learning Disabilities								
Intermediate Care and Rehabilitation Inpatient Wards			√		√	√		<input type="checkbox"/>
Neuro-rehabilitation Inpatient Services						√√		<input type="checkbox"/>
Brent Rehabilitation Service					√	√		<input type="checkbox"/>
CMH A&E Front of House/ Wembley Walk In Centre								<input type="checkbox"/>
District Nursing		√√	√√	√	√√	√√		<input type="checkbox"/>
Community Matrons		√√	√√		√√	√√		<input type="checkbox"/>
Stoma				√	√			<input type="checkbox"/>
Continence	√√	√√			√√	√		<input type="checkbox"/>
Nutrition and Dietetics	√√√	√√√	√√		√√	√√		
MSK Physiotherapy								<input type="checkbox"/>
Podiatry		√√	√√		√√			
Phlebotomy		√	√					
Brent and Ealing Wheelchair Services	√√	√√			√√	√√		<input type="checkbox"/>
Substance Misuse Service								
HIV Coordinator							√√√	
Primary Care Mental Health Service					√√			
Community Dental Service	√√√				√√√			
Care pathways: Diabetes Cardiology Dermatology Respiratory		√√√	√√√		√√√			<input type="checkbox"/>
Retinal Screening Programme		√√						
Infection Control							√√	

Key

√ Primary Prevention
√ Secondary Prevention
√ Tertiary Prevention

4.3.3 Vulnerability to Competition

Vulnerability to competition has been assessed by considering:

- Whether or not commissioners hold strong views on market testing the service;
- How the service compares, in cost terms, with competitors, based on benchmarking data (where this is available);
- The nature and scale of alternative supply, either within or outside the NHS family;
- Whether, up and down the country, market testing activity for the individual service is significant and/or growing²³.

Figure 4.5 shows how Brent Provider Services service portfolio performs when Fitness for Purpose is mapped against Vulnerability to Competition.

Figure 4.5: Assessment of vulnerability to competition

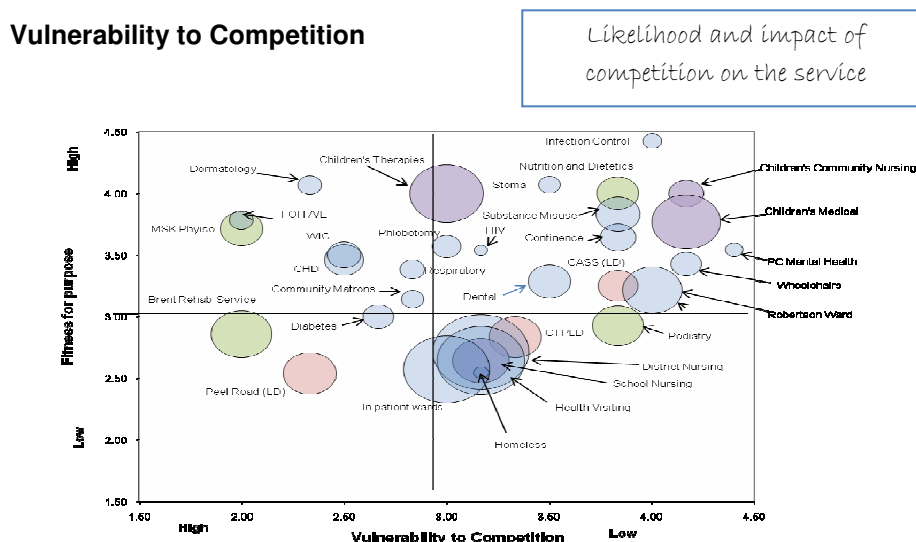


Figure 4.5 identifies a number of services which are at risk of potential competition. The assessment of competition has been influenced by the Service Leads the level of commissioner satisfaction with the current service provision and knowledge of local competitors, who in the main are neighboring PCTs, Acute and Mental Health providers. It is noteworthy, that whilst there may be a number of potential competitors for some services (**See Figure 4.6**), those assessed as having a low fitness for purpose may be less attractive when examined by potential competitors.

²³ Tribal/AT Kearney has now produced two reports on the competitive environment for community health services. Copies are available on the PUK Programme E-Room and can be obtained from the PWT.

Figure 4.6: Potential Competitors

Care Setting	Health Care Continuum				
	Primary Prevention	Prevention: People at High Risk	Immediate Intervention	Continuing Care	End of Life Care
Own Home	NHS Brent Other PCTs	NHS Brent Other PCTs Private company	NHS Brent Other PCTs Acute Trusts Private company Voluntary sector	NHS Brent Other PCTs Mental Health Trust	NHS Brent Other PCTs
Meeting Place	NHS Brent Other PCTs Voluntary sector Local Authority	NHS Brent Other PCTs	NHS Brent Other PCTs Acute Trusts GPs Mental health Trust Voluntary sector	Mental Health Trust	Voluntary sector
Clinic	NHS Brent Acute Trusts	NHS Brent Other PCTs Acute Trusts	NHS Brent Other PCTs Acute Trusts GPs Mental health Trust Voluntary sector	NHS Brent Other PCTs Acute Trust	N/A
Bedded Unit	N/A	Acute Trust Mental Health Trust	NHS Brent Acute Trust Nursing/Residential Homes	Local Authority Nursing/Residential Homes	Nursing/Residential Homes
Acute	N/A	NHS Brent	NHS Brent Acute Trust Out of Hours providers	Acute Trust	Acute Trust
Hospice	N/A	N/A	Nursing/Residential Homes Local Hospices	Nursing/Residential Homes Local Hospices	Nursing/Residential Homes Local Hospices

Services which are assessed as having a medium degree of Vulnerability to Competition are:

CTPLD – In many areas, LD services are aligned with Mental Health provision. This service may be attractive to the local Mental Health Trust.

Dental - The provision of dental services may be attractive to neighboring community Providers and/or private providers.

District Nursing, School Nursing and Health Visiting – These are all typically core community provider services. Neighboring community providers all have expertise in delivering these services and may be able to demonstrate greater strength in developing these services to ensure they are Fit for Purpose.

Children’s Therapies - The provision of paediatric therapy services may be attractive to neighboring community providers and/or the local authority or private providers

HIV Coordinator– The service has a history of working with the voluntary sector. The Terrence Higgins Trust is active within this area and is a credible provider.

Homeless – The service model may be attractive to voluntary organisations and/or the GP practice which has already been commissioned to deliver similar services to homeless people.

In-Patient Wards – This facility has the potential for expansion in response to commissioner requirements to develop intermediate care. Potential competitors would be the acute trust and neighboring community providers.

Phlebotomy - This service was originally set up as a pilot in 2005 after the withdrawal of provision by the local acute trust. GPs could easily deliver this service.

Services which are assessed as having a high degree of Vulnerability to Competition are:

CMH A&E Front of House and the Walk-in-Centre – The CMH A&E Front of House service is currently housed by the local Acute Trust. The Walk-in-Centre is provided by the local out-of-hours cooperative but managed by Provider Services on behalf of NHS Brent Commissioners. It is felt that that management control and budget for this service could be provided directly by the out-of-hours provider.

Community Matrons – This is a typically core community provider service. Neighboring community providers have expertise in delivering this service and may be able to demonstrate greater strength in developing and expanding this service.

Diabetes, CHD Respiratory and Dermatology Pathway Services – These services provide specialist care within a community setting and may be attractive to primary care providers if they are able to provide these services at lower cost and/or acute care providers who may wish to extend their portfolio to include community based care.

Peel Road - In many areas, LD services are aligned with mental health provision. This service may be attractive to the local Mental Health Trust or a private provider

Brent Rehabilitation Service – This service may be attractive to private providers who are demonstrating growing interest across the nation in providing therapy services.

MSK Physiotherapy – There are a number of credible providers in local acute trusts and private providers are developing their skills in this area.

In considering which services are Vulnerable to Competition, it is prudent to explore the impact on the provider budget if such services were to be lost to competition. **Table 4.5** presents detail of the income for each of these services expressed in monetary value and proportion of provider business alongside the key benefits of retaining these services within the portfolio.

Table 4.5: Financial analysis of services vulnerable to competition

Service	Budget	% of total portfolio	Benefits of retaining this service
CTPLD	£1,068,307	2.7	A key element in the provision of integrated health and social care to people with learning disabilities. May be attractive if other LD services are provided by the Provider to deliver maximum efficient scale
Community Dental Service	£4,537,627	11.4	Significant budget with the potential to attract income from a broader range of commissioners
District Nursing	£4,537,627	11.4	Significant budget and a core community provider service.
School Nursing	£1,583,349	3.9	Core community provider service with close alignment with Health Visiting services
Health Visiting	£4,009,371	10.1	Core community provider service which makes a significant contribution to Provider Services budget
Children's Therapies	£2,856,897	7.2	Aligned with Children's Medical, Children's Community Nursing and School Nursing services. Medium size service
HIV Coordinator	£82,770	0.2	
Homeless Service	£106,810	0.3	
Intermediate Care and Rehabilitation Inpatient Wards	£4,655,805	11.7	Forms a key element of future service offerings related to intermediate care. Makes a significant contribution to Provider Services budget
Phlebotomy	£868,176	2.2	Provides support to District Nursing and the Pathway services
CMH A&E Front of House	£315,511	0.8	
Wembley Walk In Centre	£762,838	1.9	
Community Matrons	£236,104	0.6	Close alignment with DN services
Care Pathways: Diabetes, Cardiology, Respiratory, Dermatology	£1,967,924	4.9	Provides a potential area for growth and income generation
Peel Road Unit	£3,906,530	9.8	
Brent Rehabilitation Service	£1,870,711	4.7	Forms a key element of future service offerings related to intermediate care and rehabilitation services. Close alignment with inpatient wards
MSK Physiotherapy	£1,367,676	3.4	Potential area for growth and income generation

Note: Budget figures include all direct and indirect costs.

4.3.4 Risk

Exposure to Risk has been assessed by considering:

- The degree of volatility in activity involved in providing the service;
- The level of the clinical/operational and/or financial risk faced by the service; and
- The degree of difficulty of the governance task required to assure that a clinically safe and effective service is being delivered.

Figure 4.7 shows how Brent Provider Services service portfolio performs when Fitness for Purpose is mapped against Exposure to Risk.

Figure 4.7 Assessment of Risk

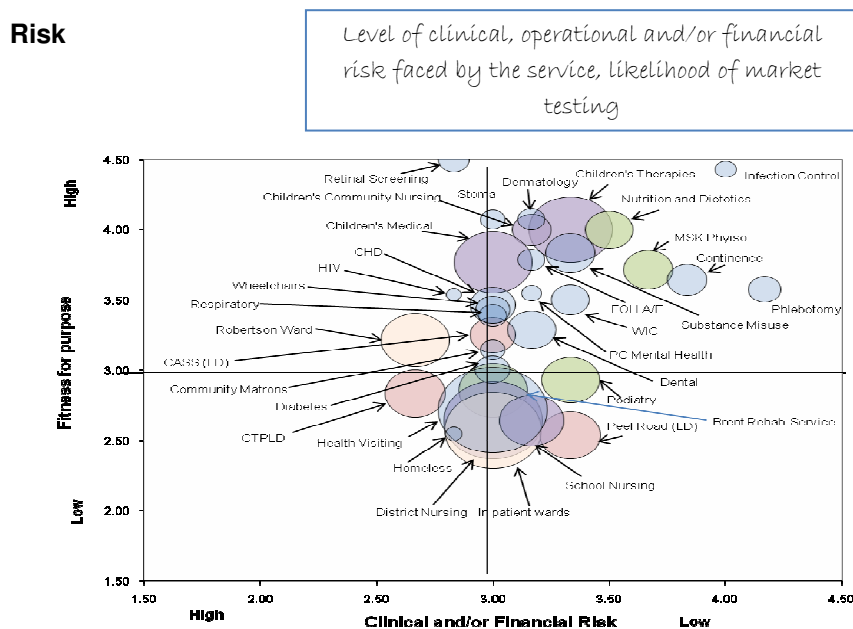


Figure 4.4 shows that a number of services appear to be exposed to reasonably significant levels of risk. There are two key points to be considered before exploring the assessment of risk at service level. These being:

- The assessment of services do not take into account possible financial risks that may be present as analysis of financial performance against budget has not been possible due to the re-setting of budgets for the year 08/09 and time involved in completing the year end forecast of cost against budget.

- The Confirm and Challenge process identified a number of clinical risks present within some services. The assessment of the level of clinical risk for the purpose of the service assessment and review process has been undertaken based on the Service Lead and Assistant Directors interpretation of those risks at that point in time. However, where risks have felt to be material, further independent analysis of those services has taken place. The reassessment of risk based on independent review of these services has not been reflected in the assessment of risk within the strategy.

Services presenting high risk can be categorised as those which present:

- a) a high Risk and low Fitness for Purpose,
- b) those with medium Fitness for Purpose but which face high Risks, and
- c) those with high Fitness for Purpose but which face high Risks

High level of Risk and low Fitness for Purpose

The **Homeless Service** exhibits both operational and clinical risks. This is a small service of 1.0 WTE school nurse and 0.5 WTE adult nurses. The mental health nurse establishment was removed as part of Turnaround. Clinical risk is attributed to the low level of mental health supervision and development available to the team; no formal systems of clinical governance are in place and service provision stops during school holidays due to the term-time only working arrangements of the current team. Operational risk is associated with the model of working which is predominantly through lone working arrangements; the team report that they 'case find' their clients by visiting local parks and places known to comprise people who sleep on the streets. This poses significant staff safety risks. Alternative provision for this population groups has been commissioned through a local primary care provider.

CTPLD faces a number of operational and clinical risks. The client group is highly vulnerable and the clinical governance is complex with multi agency interventions. There is a lack of external clinical support for some members of this team. Day to day management of the team is provided by the Local Authority and until recently has lacked senior clinical leadership. In addition, significant funding was withdrawn during Turnaround. The service is now operating with limited scale and is not well placed to cope with changes in demand.

The **District Nursing Service** report that they are not able meet the volume demand for the service from patients and as such it faces challenges in being able to demonstrate that it delivers safe and effective care. Low levels of investment in skills development, challenges in recruitment and high levels of sickness all contribute to the high levels of clinical and operational risk exhibited by the service. The service is currently under external review to examine issues of safety, effectiveness and service model. There are low levels of satisfaction with the service from the GP community

Health Visiting is providing a more restricted service than neighboring boroughs and as such it faces challenges in being able to demonstrate that it delivers safe and effective care in line with its statutory requirements. Low levels of investment in management, skills development, challenges in recruitment and high levels of sickness all contribute to the high levels of clinical and operational risk exhibited by the service. The service is currently under

external review to examine issues of safety, effectiveness and service model. There are low levels of satisfaction with the service from the GP community

The **Intermediate Care and Rehabilitation Inpatient Wards have been** externally reviewed to examine issues of safety and effectiveness. Low levels of investment in management, skills development, challenges in recruitment and high levels of sickness all contribute to the high levels of clinical and operational risk exhibited by the service. Commissioners are in the process of considering how intermediate care should change which will impact on the future service delivery model of the In-patient wards.

The **Brent Rehabilitation Service** appears to be well organised and posed a low level of clinical and operational risk. However, Commissioners were concerned about this service due to perceived access issues and the services inability to evidence achievement of clinical outcomes, admission avoidance, prevention of falls and delayed discharges. As commissioners develop NHS Brent intermediate care strategy there is a risk that this service will be market tested in the future

High Level of Risk, medium level of Fitness for Purpose

The **Neuro-rehabilitation Inpatient Services** faces clinical, operational and financial risks. Clinical risks are attributed to the nature of care required by the client group whilst operational risk is posed by the lack of formal agreement of cover arrangements and clinical supervision of the lone medical consultant. The service is currently under external review to examine issues of safety and effectiveness. Financial risks are associated with the costs of estate occupied by the service which has the potential to render the service expensive and the potential loss of income from neighboring PCTs who commission capacity from the service but are not utilising that capacity.

The **Care Pathway Services** face high levels of financial risk. These services are felt to be expensive yet activities such as provision of training and consultancy to other PCT commissioners and providers is provided free of charge to recipients. Further work is required to accurately cost the delivery of the Pathway Services and enable the calculation of cost benefit.

The **Community Matron Service** is a pilot and is under review. The service was originally funded from vacant posts within the district nursing Service. Potential with-drawl of the service following commissioner review may see the funding attributed to this service being removed. The service also exhibits high level of clinical risk due to the lack of formal mentorship and supervision arrangements for team members and nature of interventions provided by the team to a cohort of the population who have complex health needs

CASS exhibits financial risk due to high staff to patient ratio and lack of cost benefit analysis.

The **Brent and Ealing Wheelchair Service** exhibits financial risk due to upward trends in equipment costs and changing wheelchair usage which renders a low level of control over the cost of equipment used within this service.

High level of Risk and high Fitness for Purpose

The **HIV Coordinator** is a service which poses considerable clinical and operational risks mainly linked to it comprising a sole worker who operates autonomously and the lack of

visual patient data systems and processes. The sole worker is a highly autonomous practitioner who appears to have a role in managing and developing HIV networks (which could be viewed as a commissioning function) and also delivering care to people with HIV. Lack of cover arrangements means the individual provides care outside of normal working hours and cover arrangements for holidays and sickness are not available (cover is either provided by the post holder via telephone or services are not available during that time). Clinical governance of the service is complex as much of the care coordinated by the Post Holder is delivered through networks of third sector organisations and/or voluntary groups. Commissioning expertise for this service also sits with the Post Holder which again poses risks to the PCT if this person was not available for work.

Retinal Screening Service faces financial risks. Although this is a well run service, the costs of the service need to be clarified. Further understanding is required of the impact of using reception staff and two sites at the local acute hospital, the cost of which is not included in the overall cost of the service. There is also a risk of a budget overspend this year due to the rising demand on this service.

4.3.5 Management Challenge

The scale of management challenge involved in running and developing service lines has been assessed by examining whether:

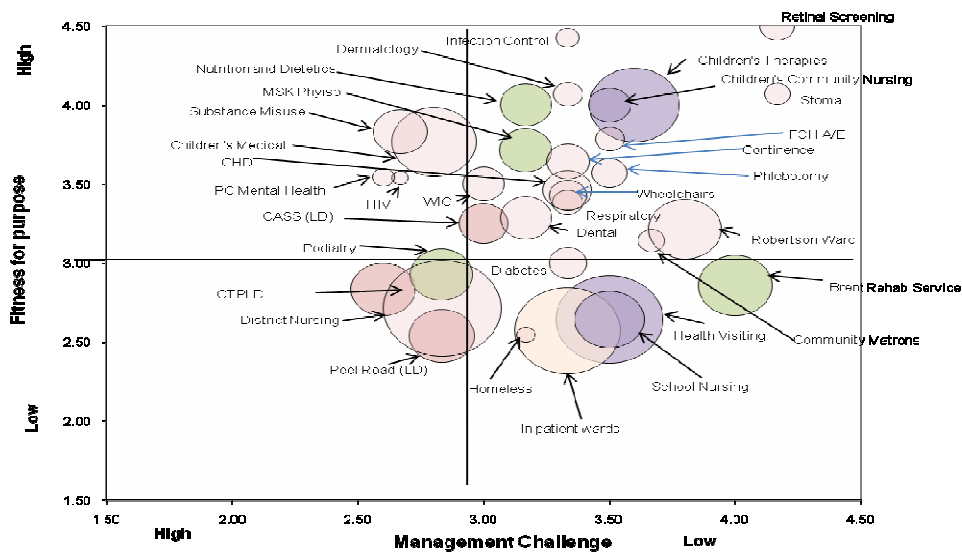
- The nature and level of management resource is in place to meet the opportunities and challenges identified;
- Strong professional leadership is in place;
- The service is straightforward or complex to manage;
- How much management influence Provider Services exerts over the performance of the service line.

Figure 4.8 shows how the Brent Provider Services service portfolio performs when Fitness for Purpose is mapped against Management Challenge.

Figure 4.8 - Scale of Management Challenge

Management Challenge

Examining the scale of the management effort required to deliver the service to its best potential



The analysis indicates that there are significant management challenges for a number of services. There are a number of common themes which have influenced this level of assessment. This includes:

- Lack of previous consistent management focus and clinical leadership at senior management level** – reductions in management resource across the PCT and frequent changes in senior leadership over the last few years has had a significant impact on all services within the provider portfolio. This is more apparent in the large core provider services such as health visiting, district nursing, school nursing and the bedded units. Capacity to support service development has been limited and as such, management resource has been focused on dealing with issues that become apparent with little or no focus on putting in place sustainable solutions. In recent months the senior management and clinical leadership resource within provider services has been strengthened. Increased management attention has identified a number of significant and complex service delivery issues which are in the process of being explored in greater depth and resolved through targeted management attention. Recruitment of a permanent senior management team is being progressed at pace.
- Challenges in the recruitment of staff** - Brent Provider Services was subject to a recruitment freeze in the later part of last year with many vacant posts being disestablished to as part of the financial control measures. The recruitment freeze was lifted in April 2008. Challenges in recruiting high caliber staff from a limited pool of supply is felt to be hampered by the perceived negative reputation of NHS Brent as a PCT and employer of staff. Many services report challenges in recruiting to

qualified community and/or therapy practitioner posts. There is a need to develop a Directorate and service level recruitment and retention strategy to facilitate the successful recruitment of new staff.

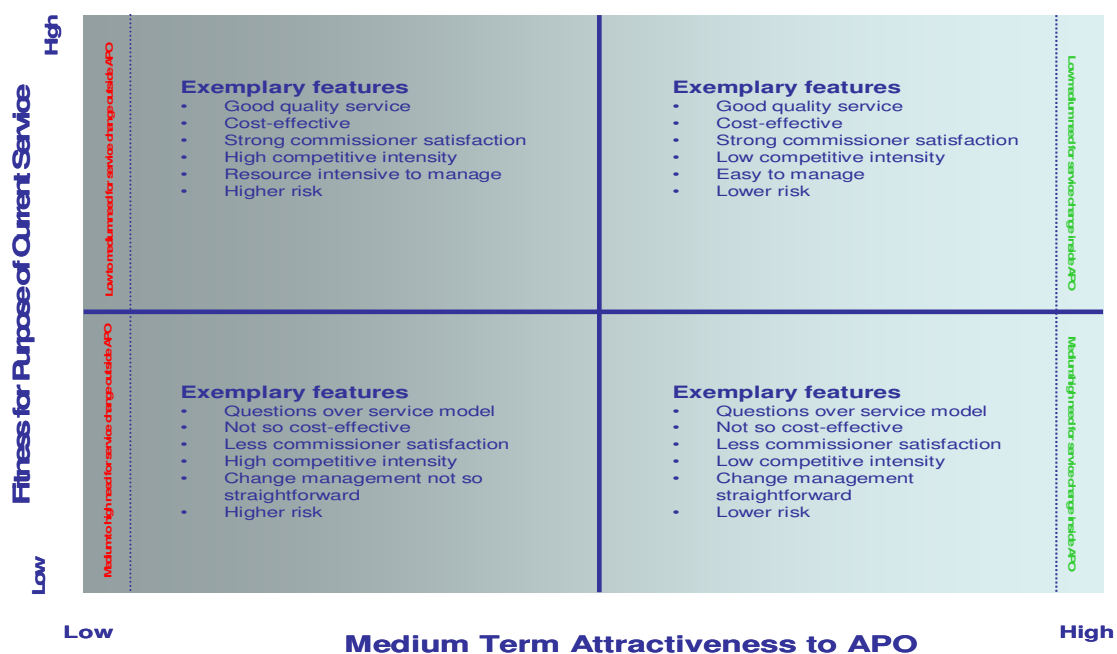
- **Sickness absence** – 50% of Brent Provider Services have a high level of sickness absence which is above the national average. Pro-active management of sickness absence is now underway. There is a need to review sickness and absence procedures to ensure they facilitate more timely resolution of sickness issues
- **Service names** – There are several services within the provider portfolio that do not deliver services which are implied by the name of the service (such as MSK and the pathway services). This leads to external confusion about what the service is expected to deliver and confusion within the service about what activities the service should focus on. This in turn leads to the management of actual against expected service performance challenging and time consuming for service leads and senior managers within provider services.

4.3.6 Overall Assessment

The ultimate test applied to each Service Line is whether or not it will be attractive, in the medium term, to a community health services provider that is required to operate in future in a truly business-like fashion.

Using the Fitness for Purpose criteria as the common axis, all scores can be combined to produce an overall index of “attractiveness” for each service. In these terms, a highly attractive service line simply means, in relative terms, one with high strategic fit, low vulnerability to competition, low risk and limited management challenge. **Figure 4.9** identifies some exemplary features of service lines that might fall into each of the four quadrants of the graph.

Figure 4.9 – Exemplary Features



Services that appear demonstrably fit for purpose are located in the top half of the graph, whilst services that are likely to appeal to a community health services provider are located in the right half. As illustrated, a service becomes increasingly attractive as it moves further to the right of the matrix. So, services that are located in the bottom right quadrant of the graph remain inherently attractive, but do present clear development challenges. Those in the top right quadrant are most obviously attractive.

Those located in the top left quadrant function demonstrably well, but may perhaps lack clear Strategic Fit and/or might prove to be distracting for scarce management resource. Finally, those services located in the bottom left quadrant also present clear development challenges, but they are challenges that a community health services provider might rationally choose **not** to accept.

Figure 4.10 identifies the co-ordinates of each of the 31 services lines assessed, as plotted by the PWT, following the completion of the Service Line Reviews and evaluation process.

Figure 4.10 – Overall Attractiveness of Service Line to APO

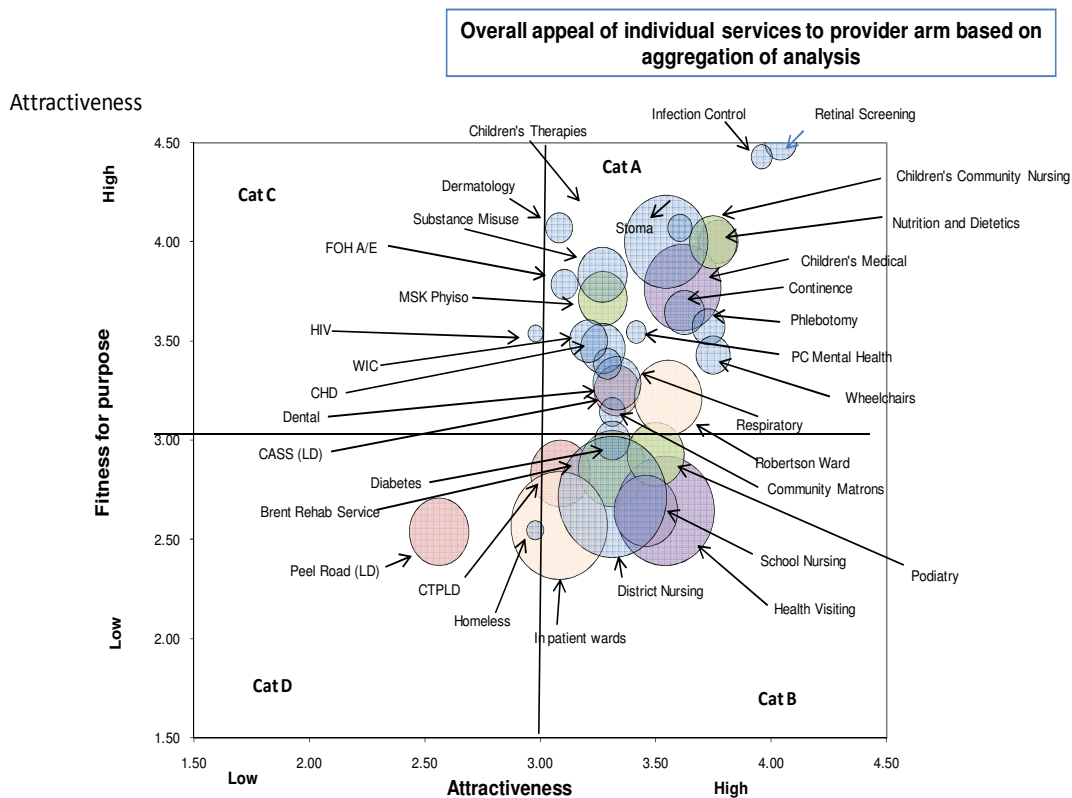


Figure 4.10 indicates that 20 of the 33²⁴ services reviewed are potentially attractive to Provider Services for inclusion in its service portfolio going forward, with a further 10 being

²⁴ each element of Children's Medical and Nursing Services and Learning Disabilities considered separately

potentially attractive following a focused period of development. However, the presentation of attractiveness aims to inform but not replace decisions about the nature and shape of the future provider portfolio; the positioning of future services will also be informed by the outcome of the Commissioners review of services and changed priorities.

It should be noted that the Integrated Care Coordination Service (POPP) has not been included in the **Table 4.6** as this service is a pilot and subject in to commissioner evaluation which will inform the future service model.

Services are categorised as:

- **Category A** – be **retained in the long term** and developed by Provider Services as part of its core service portfolio.
- **Category B** – be **subject to a focused period of redesign and then re-assessed** by NHS Brent and Provider Services within an agreed period to consider future long term inclusion within the provider portfolio
- **Category C** – to be **considered for transfer** to other providers or parts of the PCT.
- **Category D** – should be **discontinued** and/or the PCT’s requirements substantially re-framed so that a significantly different service model results.

Table 4.6 Identifies which services fall into which categories

Table 4.6 Service Categories

Category	Service Line
Category A	<ul style="list-style-type: none"> • Brent and Ealing Wheelchair Services • Continence • Infection Control • Nutrition and Dietetics Service • Retinal Screening Service • Stoma • Children’s Medical Service • Children’s Community Nursing Services • Children’s Therapy Services • Neuro-rehabilitation Inpatient Services • Substance Misuse Service • CMH A&E Front of House • Wembley Walk In Centre • Community Dental • Community Matrons • Phlebotomy (see note below) • Care Pathways: <ul style="list-style-type: none"> ○ CHD ○ Respiratory ○ Dermatology • The Community Activity Support Service (CASS) • MSK Physiotherapy • Primary Care Mental Health Service
Category B	<ul style="list-style-type: none"> • Brent Rehabilitation Service • District Nursing • Care Pathways: <ul style="list-style-type: none"> ○ Diabetes • Podiatry • School Nursing • Health Visiting • The Community Team for People with Learning Disabilities (CTPLD) • Intermediate Care and Rehabilitation Inpatients
Category C	<ul style="list-style-type: none"> • HIV Coordinator
Category D	<ul style="list-style-type: none"> • Peel Road Unit • Homeless Service

The overall assessment of services has identified three services with little appeal for Provider Services. Discussions with Commissioners regarding the future positioning of these services are underway. These are:

Homeless Services – This is a small service that has been in existence for a number of years. The services provided by the two part time staff members is predominantly one of sign posting to mainstream health services and supporting individuals social care needs. Primary health care services for homeless people has been commissioned through a GP Practice within Brent, which has superseded the need to have a separate, discreet Homeless service

Peel Road – Peel Road is a long stay residential unit for people with profound learning disabilities. The predominant needs of the people who reside within the unit are more closely aligned to social care. The service model requires modernization to meet the national quality standards relevant to the care of people with Learning Disabilities

HIV Coordinator – this service is delivered by a sole practitioner who focuses the majority of his time on developing and coordinating a network of third sector organisations to provide social care support to people with HIV. The coordinator also provides expert advice and support to people with HIV who are under the medical care of an acute trust physician. Delivering a service through a lone practitioner presents high levels of operational risk. It is felt that this service is more closely aligned to sexual health or social care services.

The remaining services have demonstrated that they are attractive for the Provider to continue to provider. However, it is important to note that these are recommendations for discussion, rather the final view of the PCT. While a number of services may, for the provider, be highly attractive to continue to provide, there may be compelling reasons to integrate these services with other providers. Examples may be some children's services and the walk in centre. Integration with another organisation may have greater benefits for patients. Categorisation of services within the Provider Portfolio will inform discussion within the PCT and with potential Alliance partners regarding the nature and shape of the future Provider Portfolio as it develops as an Autonomous Provider Organisation. A range of conclusions may be reached from those discussions. These include:

- **Conclusion 1** - Recognise the challenges inherent in running, developing or strengthening a service, adopt the service as part of NHS Brent Provider Services in the long term and resolve to put in place appropriate solutions to those challenges; or
- **Conclusion 2** - Adopt the service as part of Provider Services in the short to medium term, but, in doing so, both NHS Brent and Provider Services commit to work together to address the challenges and to share risks in doing so. Equally, both NHS Brent and Brent Provider Services will, after an agreed period, formally re-assess whether significant headway has been made to resolve the challenges; or
- **Conclusion 3** - Choose not to introduce the service as part of the Provider Services portfolio.

4.4 Summary

Section Four of the provider development strategy has presented a detailed analysis of the 31 service lines included within the current portfolio of Provider Services. Based on the

assessment of services against six points of analysis, services have been grouped into four categories which inform decisions about the future positioning and development of individual services.

Services are categorised as:

- **Category A** – be retained in the long term and developed by Provider Services as part of its core service portfolio.
- **Category B** – be subject to a focused period of redesign and then re-assessed by NHS BRENT and Provider Services within an agreed period to consider future long term inclusion within the provider portfolio
- **Category C** – to be considered for transfer to other providers or parts of the PCT.
- **Category D** – should be discontinued and/or the PCT's requirements substantially re-framed so that a significantly different service model results.

Each service is in the process of reviewing their development requirements and formulating individual service development plans based on the assessment of their service. These plans will be reviewed and integrated into the Provider Service Business Plan.

The majority of services have demonstrated that they are attractive for the Provider to continue to provide. However, it is important to note that these are recommendations for discussion, rather the final view of the PCT. While a number of services may, for the provider, be highly attractive to continue to provide, there may be compelling reasons to integrate these services with other providers. Examples may be some children's services and the walk in centre. Integration with another organisation may have greater benefits for patients. Categorisation of services within the Provider Portfolio will inform discussion within the PCT and with potential Alliance partners regarding the nature and shape of the future Provider Portfolio as it develops as an Autonomous Provider Organisation. A range of conclusions may be reached from those discussions. These include:

- **Conclusion 1** - Recognise the challenges inherent in running, developing or strengthening a service, adopt the service as part of NHS Brent Provider Services in the long term and resolve to put in place appropriate solutions to those challenges; or
- **Conclusion 2** - Adopt the service as part of Provider Services in the short to medium term, but, in doing so, both NHS Brent and Provider Services commit to work together to address the challenges and to share risks in doing so. Equally, both NHS Brent and Brent Provider Services will, after an agreed period, formally re-assess whether significant headway has been made to resolve the challenges; or
- **Conclusion 3** - Choose not to introduce the service as part of the Provider Services portfolio.

The final sections of the strategy provides an analysis of the future nature and shape of Provider Services as a contestable, *fit for purpose* and *fit for business* provider of community services and makes recommendations for the development of Provider Services.

5. Becoming a World Class Provider and Provider of First Choice

The main aim of **Module 1** of the Provider Services development programme is to inform the PCT's decisions about the composition of the future portfolio of services for Brent's Provider Services as well as identifying the principal service challenges and opportunities that lie ahead. In doing so, gaps in capability and capacity that may be impeding the Provider Services from operating in a more business-like way are identified.

Section Four of this document explored individual services within the current provider portfolio making recommendations for the future positioning and development of those services. **Section Five** will focus on the Provider Services moving forward as a contestable, *fit for purpose* and *fit for business* provider of community health services.

The content of this section has been informed by the analysis of finance, workforce and activity data, findings from the process and outcomes of the service line reviews and discussions with key personnel within the PCT.

5.1 Brent Provider Services Future Vision

The ambition of NHS Brent Provider Services is twofold. First, to provide the best care possible to the population it serves by providing care which is sensitive to the diverse needs, cultures and characteristics of the population, is responsive to local health need and reduces health inequalities. Second, it is to operate in business-like fashion so that it can play a full role alongside commissioners, users and patients in designing, developing and delivering clinically and cost effective care services. To realise its ambition Brent Provider Services needs to understand its capabilities and development needs which, in turn, will inform opportunities for the future development of its service portfolio.

NHS Brent's Primary and Community Commissioning Intentions (2008-09) acknowledged that Provider Services would play a key role to play in supporting the strategic shift of services from hospital-based care to care closer to home. Particular emphasis is placed on reducing emergency admissions, provision of intermediate care and rehabilitation services, assertive management of people with Long Term Conditions, widening access, reducing health inequalities and supporting the achievement of the 18 week referral-to-treatment target. To inform decisions about the future nature and shape of Provider Services, NHS Brent has posed 5 key questions:

- Do you provide services that commissioners what to buy and invest in?
- Can you measure what you do?
- Are you able to provide services that can respond to changing need?
- Do you provide value for money?
- Do patients like your services?

The existing scope of Provider Services' business is very broad, spanning community health and dental services, clinic-based services for the management of Long Term Conditions, unscheduled care, in-patient step down and neurological rehabilitation care and care for people with profound learning disabilities. Services are infrastructure-dependant and occupy a large estate.

In the main, the scope of Provider Service's current portfolio is strategically aligned to commissioners' requirements. However, the review and assessment of services, undertaken as part of the Provider Services Development Programme, has identified that the majority of the core provider services, (comprising district nursing, health visiting, school nursing and in-patient services) require considerable development to ensure they are delivering care which is safe, of value and of high quality: in other words, **services which commissioners will want to continue to buy and invest in.**

NHS Brent commissioners have already signaled their intention to review requirements for intermediate care. They have given notice to Provider Services of their intentions and have confirmed that these reviews may lead to re-provision of the services by alternative suppliers. The challenge for Provider Services is to remain focused on developing its core services, to ensure they are safe and clinically effective, whilst understanding the strengths and shortcomings of Provider Services in providing intermediate care, before determining how they respond to changing commissioner requirements, either in Brent or elsewhere.

As with many Provider Services, **measuring performance** is challenging but an area in development. The first challenge is to understand what level of performance and quality is expected. At present, services are commissioned through block contracts, with expected performance articulated within individual service specifications, often expressed as activity verses outcome measures.

Like in many PCTs, systems and processes to measure activity are not well developed. The implementation on the community information system (RIO) will facilitate the provision of timely and accurate information. In developing RIO, it is imperative that data sets are aligned with performance metrics and that an information culture is developed within Provider Services through the development of skills, knowledge and behavior across all staff groups. The move from activity to outcomes-based measurement requires the development and implementation of an agreed outcomes framework to be utilized in all contracts for service.

One of the key questions asked is whether Provider Services is able to provide services that can **respond to changing need**. This requires a degree of nimbleness which is reliant on three things a) having a workforce with skills and competencies that are adaptable to changing care requirements, b) having the leadership and management capability to transform services and c) having the freedom to flex the use of human resources, equipment and facilities to deliver services in different ways, all of which present challenges to Provider Services at this time.

Provider Services recognises the need to develop greater nimbleness. Work to put in place a substantive senior management team, with strong clinical and service transformation skills, has started. The future work plan would benefit from further exploration of these three facets of nimbleness, particularly focusing on the assessment of skills within the existing workforce, which in turn should inform the content of future workforce development strategy.

Demonstrating value is hampered by the lack of accurate finance, workforce and activity data and an agreed definition of value. Traditionally, value has been expressed in terms of cost, but if true value is to be experienced by patients, then the move to an outcomes currency for value is required.

With increased demand being placed on NHS resources through changes to the demographics of the population, changes to lifestyle and people's expectations, there is a growing role for community providers in preventing disease onset and/or disease escalation with all the attendant implications for health care resource. Without exception, all services within Provider Services' portfolio were able to articulate their contribution to the prevention agenda. Despite this, their ability to demonstrate cost-benefit (in terms of avoiding costs that would otherwise be incurred) is challenged by the lack of skills in defining which interventions deliver which outcomes and how cost-benefit is calculated and reported.

The analysis of service cost (presented in Section 3 of this report) confirms Provider Services' view that their services are more expensive than others: attributed in the main to the high indirect costs associated with, amongst other things, the cost of the community health estate. An analysis of estate requirements is underway. It is recommended that the cost of care provision is recalculated once better information on estates utilisation is available.

Understanding if patients like the services delivered is currently measured by the number of complaints a service receives. While complaints management is essential, on its own it does not provide a full enough picture to judge the level of patient satisfaction. Anecdotal evidence from service leads shows high levels of patient satisfaction with the services they receive and a number of written compliments are received but not formally recorded. Some services within Provider Services are in the process of completing a formal patient survey to ascertain views. This information will be used to inform the development of services.

5.2 Summary

The ambition of NHS Brent Provider Services is to provide the best care possible to the population it serves by providing care which is sensitive to the diverse needs, cultures and characteristics of the population, is responsive to its health needs and reduces health inequalities; and at the same time is business like in its approach to the development and delivery of care services. To realise its ambition, assessment of the Provider Services' capabilities has taken place and gaps identified. Assessment of capability has been informed by examination and assessment of services against six key areas of analysis, analysis of finance, estates, workforce and activity data, discussions with key stakeholder and consideration of the findings of the service reviews with key PCT personnel.

In the main, the existing scope of the Provider Services portfolio is strategically well-aligned with commissioners' requirements for community health services. However, the review and assessment of services, undertaken as part of the Provider Services Development Programme, has identified that the majority of the core provider services, (comprising district nursing, health visiting, school nursing and in-patient services) require considerable development to ensure they deliver care which commissioners will, in the future, want to buy and invest in. Investment in and development of these services is underway and is being driven by a strong and credible management team.

Brent PCT Provider Services recognises that understanding its services and the capabilities needed to be the provider of choice in the local area is the start of a journey of development. This journey will only be completed when Provider Services uses learning gained from the

work it has undertaken to examine its services to formulate a coherent and achievable development plan for the provider organisation as a whole..

6. Achieving Greater Separation between PCT Commissioning and Provider Activities

The main body of this NHS Brent Provider report has concentrated, on two key areas;

- i. exploring how best value can be achieved in service provision by examination of individual services against six points of analysis and,
- ii. exploring the ambition and associated capabilities of Brent Provider Services to become a sustainable and contestable business renowned for world class provision.

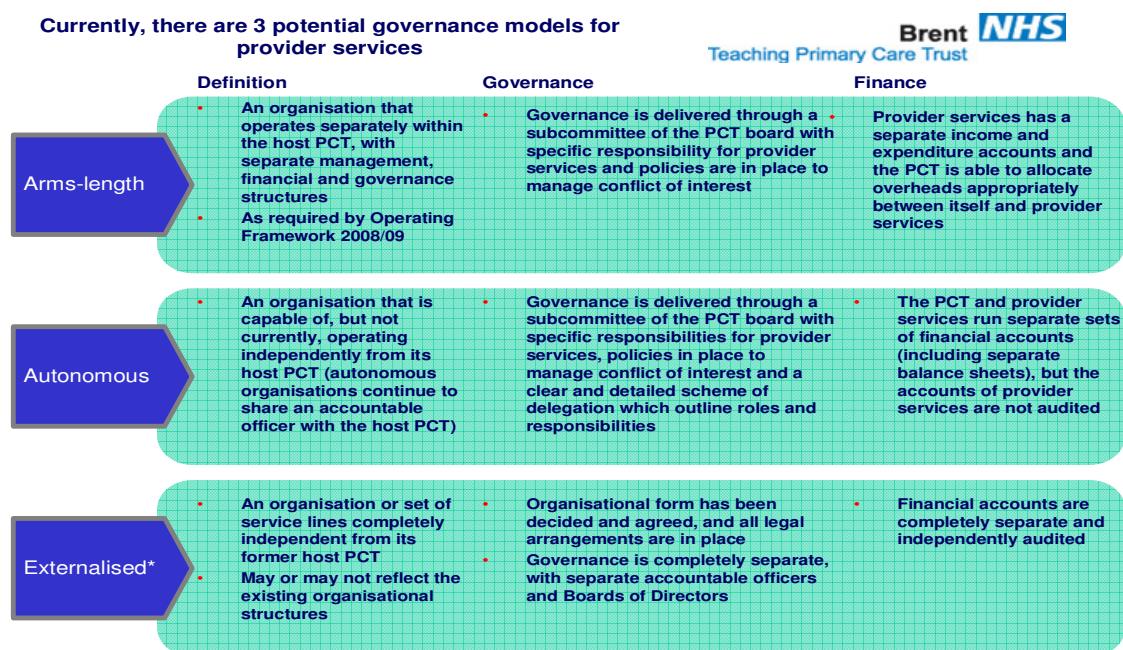
The 2008/09 operating plan requires PCTs to separate their core commissioning activities from their provider activities. In this context, the term 'separation' describes a clear delineation of commissioning and provider activities. Whether this separation leads to externalisation outside the PCT is a matter which each PCT Board will determine. However, the NHS London view is that PCTs cannot both be world class commissioners and providers of community services and it expects provider services to achieve Autonomous Provider Organisation (APO) status by April 2009 (or soon afterwards by agreement).

The extent of separation can be described at three levels:

- Arm's length (separate governance arrangements within the PCT)
- Autonomous (own corporate functions within the PCT) and
- Externalised (complete independence from the PCT).

Figure 6.1 illustrates the key differences between each of these levels of separation, summarising the associated governance and financial management mechanisms that would feature.

Figure 6.1: Levels of Separation



* NHS London does not expect to see 31 provider services externalised from their PCT

NHS Brent has begun the process of externalisation. This is marked by the formal establishment of the Provider Services Sub Committee of the PCT Board.

Arm's length separation requires the PCT Board to continue to act as the sole decision making body for Provider Services, holding the provider to account for achievement of national and local priorities and quality standards. Maintaining separation in the near term will provide space for Provider Services to develop capability and capacity to operate more autonomously. It will also provide the PCT Board with assurance that its own accountabilities and responsibilities are being met.

The introduction of the Provider Services Sub-Committee prevents Brent's Provider Services from becoming a peripheral part of the PCT. Nonetheless, the PCT's strategic focus will be on developing world class commissioning competences. Operational management of services does not feature prominently within this agenda.

Allowing the Provider Services Sub-Committee to focus exclusively on the delivery of community services provides the space, scope and incentive to develop world class community services, as a suitable analogue to NHS Brent's world class commissioning ambitions.

Separation of the commissioning function assists the PCT in channeling its strategic energy and effort into becoming a world class commissioner. It does this by lifting the burden of operational service management for community health services from the PCT and by removing the potential conflict of interest involved in commissioning services from an in-house provider, especially when viable alternatives are becoming available.

Creating an APO to manage the delivery of community health services is expected to give rise to benefits for commissioners, for providers of services and, ultimately for users of health services. Such benefits include:

For PCT commissioners:

- i. Allowing the PCT to channel its strategic energy and effort into becoming a world-class health improvement organisation, commissioning to maximise health gain, quality and value for money for its resident population.
- ii. Reducing potential conflicts of interest that arise when the PCT or Practice based Commissioners commission services from the PCT's in-house provider, ensuring the PCT extracts value for money on behalf of its residents and that the in-house Provider Services are treated on the same basis as other NHS health care providers²⁵.
- iii. Forcing commissioners to clearly articulate their health outcome requirements for interventions expected in community health settings.
- iv. Introducing changes in behaviour that require the PCT to manage performance in line with a rules-based system, underpinned by contractual and not line management relationships.

²⁵ *Thereby enabling the PCT to discharge its responsibilities under the NHS's Principles and Rules for Co-operation and Competition and reduce the risk of intervention by the newly created Competition Panel.*

- v. Clarifying (and therefore, modifying) core executive roles within the PCT so that first, they are closely aligned with commissioning responsibilities (for example, re-designing the clinical governance function so that it discharges the obligations of the PCT *qua* commissioner (and system manager) and not as a part-commissioning, part-providing organisation) and second, removing the burden of the PCT hosting, employing and managing a corporate support services apparatus that, in large measure, is designed, shaped and staffed to service provider requirements.
- vi. Demonstrating compliance with the competition and contestability rules.

For Providers:

- i. Allowing the APO to establish itself as a leader in developing and delivering “world-class”, innovative, value-for-money, personalized, out-of-hospital care to patients.
- ii. Strengthening the leadership and management capacity focused solely on community services, in order to improve performance in service delivery and innovation.
- iii. Encouraging the APO to pursue efficient corporate and clinical governance arrangements that are fit for the APO’s purpose as a provider of clinically effective and cost effective community health services.
- iv. Incentivising the APO, through contractual arrangements, to gain a proper understanding of inputs, costs and, increasingly outputs, of the services provided and giving the APO the freedom and resource to put in place the capacity and capability to succeed.
- v. Building partnership working with the Local Authority, local NHS and private health and social care providers and the third sector, by putting in place a secure and sustainable organisational foundation to support joined-up delivery of health and social care services.
- vi. Introducing changes in behaviour that require the APO to deliver services in line with a rules-based system, underpinned by contractual and not line management relationships.
- vii. Improving sustainability and viability, by reducing the APO’s (over) reliance on its “host” PCT, by freeing it to respond to mandates from other PCTs.

For the Local Population

- i. Receiving services that are better understood by the bodies that, respectively, are commissioning and delivering them, and where innovation in service design and delivery is encouraged.
- ii. Making unsatisfactory performance of services more transparent and removing any impediments or conflicts that might arise for commissioners in seeking alternative providers.
- iii. Having a richer supply side in place so that gaps can be filled more easily, so that poor outcomes and/or excessive costs can be addressed either by changes in

provider or, more obviously, through change in existing service delivery brought about by the genuine threat of contestability.

- iv. Redesigning the basis of the dialogue between users of services and commissioners so that new channels of communication are put in place, which do not rely overly on provider relationships with users.

6.1 The Challenges of Creating an APO

The move into an increasingly contestable market presents challenges for commissioners and providers alike. For commissioners, capabilities will need to be developed that support market development, market testing, procurement and contract management activities, as well as commissioning for integrated care and outcomes.

For community health services, one of the main market development objectives of the PCT is to create an APO that is fit for business. The PCT's interest arises not simply as caring employer of APO staff but also because market development is central to world class commissioning.

The creation of a sustainable, well-populated and liquid supply base for community services, through which the PCT's commissioning requirements can be satisfied, is one of the PCT's core commissioning roles. It is crucial therefore, to the PCT as much as it is to the APO, that an APO is created in such a way that it is able to take its place confidently and credibly alongside other care providers and that it will be able to participate, in a resilient fashion, in this market.

The scale of the capability-building exercise (for both Provider Services and commissioners) is considerable, especially when combined with progress that needs to be made on such matters as activity recording, contract currency development and information management, on commissioning and procurement and on allocating and accessing human and physical resources. The scale of the task in front argues strongly in favour of using the period as the PCT migrates from arm's length to APO separation to transition into new arrangements rather than undertaking a "big-bang" change.

6.2 The Costs of Creating an APO

Creating separation and a fit for purpose Provider Services arm will not be a costless exercise. Three types of cost pressure are likely to be introduced. These are:

- Non-recurring development costs – to develop greater organizational self-awareness and direction, to create new capabilities and to introduce greater capacity (for example, costs incurred by participating on the Partnerships UK development programme);
- Recategorised recurrent revenue costs – to be newly franked against the APO, either through a process of re-allocation of costs currently accounted for elsewhere within the PCT (such as corporate service functions) or of re-engineering existing roles (such as clinical governance and professional leadership) so that the commissioning

and provider roles are properly distinguished and responsibility passed to Provider Services for those provider roles.

- New recurrent revenue costs - introduced a result of new or augmented functions, mechanisms and/or posts being put in place in Provider Services (for example, a Provider Services Committee with independent members, contract administration capacity, business development capacity to respond to NHS tenders).

6.2.1 Non-Recurring Development Costs

Experience from other PCTs working with PUK indicates that an estimated non-recurrent budget of £150k (for third-party costs) is required to ensure robust achievement of such requirements.

6.2.2 Re-allocated Recurrent Revenue Costs

Certain costs which are currently being incurred by the PCT will be reallocated as a result of the creation of an APO. Experience from other PCTs with whom PUK is working indicates that, in the absence of peculiar features such as the PCT hosting shared service functions, between 40% to 50% of the PCT's corporate support costs typically lie with Provider Services.

Other costs are being examined as part of Module 2 not simply as a re-allocation exercise, but as a more active redistribution of functions and associated costs. Clinical governance and professional leadership are perhaps good examples of where the nature of the functions remaining with the PCT are expected to change markedly once autonomy is achieved.

Activities such as clinical profession leadership, clinical advisory activities for community health services, complaints handling and infection control may well be distributed differently between the PCT and Provider Services once autonomy. Budgets will need to be re-profiled to reflect such changes.

6.2.3 New Recurrent Revenue Costs

Some additional recurrent costs may be unavoidable in achieving APO separation. Such cost pressures take two forms.

- i. Some aspects of the corporate governance apparatus of an autonomous Provider Services will be, *prima facie*, duplicative. If an increasingly autonomous Provider Services Committee is established, with substantive delegated powers, it will be expected to operate in a professional manner and in accordance with best corporate governance practice. Members that are completely independent of the PCT may feature on the Provider Services Committee (as is happening with the Community Foundation Trust pilots).
- ii. Equally, senior executive roles will be better defined and, with significant delegated powers, posts such as the Provider Services Chief Finance Officer and Clinical Officer, will need to attract well qualified, high calibre individuals.

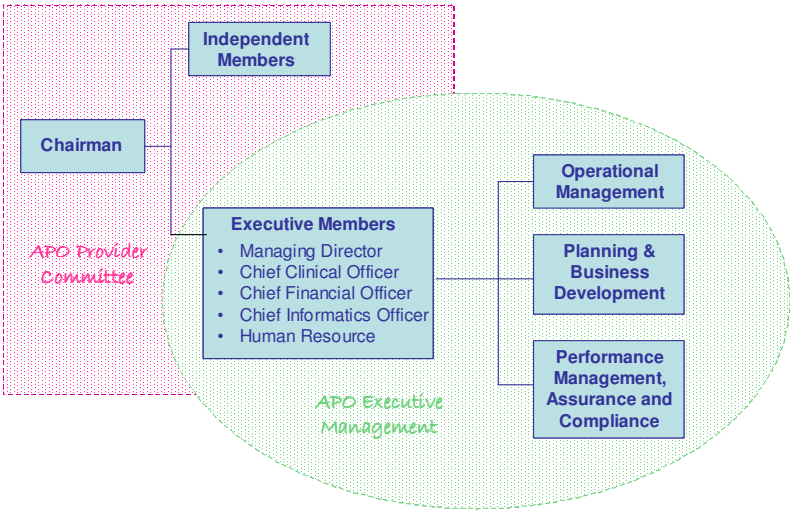
In some ways, this cost pressure is not unexpected. One of the most compelling reasons for introducing separation is precisely that important and challenging provider issues fail currently to secure the amount of senior management attention, effort and energy they merit.

Cost pressures are likely to arise from introducing new or improved capabilities and/or capacity into Provider Services. The provider development strategy acknowledges that Provider Services needs to improve in areas such as informatics, clinical leadership, performance and contractual management and service and business development, if it is to become a successful and sustainable player in an increasingly contestable market place. Three core activities have been identified as key to success. They are:

- Ongoing operational management activities;
- Planning and development activities, including service planning and business and organisation development;
- Performance management, assurance and compliance activities, including clinical governance, corporate and contractual administrative support.

Provider Services’ organisational and managerial capabilities and structure will need to be considered in the light of the above. For example, planning and development capabilities need to play a more prominent role and operational management responsibilities need to be streamlined and better aligned with strategic planning goals. **Figure 6.2** illustrates how the top management structure of a more autonomous Provider Services unit might be designed.

Figure 6.2 – Top Team Structure of the APO



The precise cost pressures arising will depend, in part, on the expected structure of Provider Services following APO creation and the outcome of any recruitment and/or secondment processes. Experience from elsewhere indicates that, in the absence of any efficiencies, a net recurrent cost pressure of around £400,000 per annum is a plausible product of the shift to hard separation. As a proportion of the Provider Services (fully absorbed) budget, this would amount to 1% of Provider Services budget.

6.3 The Next Stage for Brent PCT Provider Services

NHS Brent Provider Services has now completed Module 1 of its provider development programme and needs to determine its support requirements to move to a well developed APO.

NHS Brent, in collaboration with Ealing, Hillingdon and Harrow PCTs, has appointed a programme lead and support team over the period September 2008 through to March 2009 to identify opportunities for the creation of an alliance which will secure APO status across the respective PCTs. The arising work programme will need to take account of a range questions that will include:

- What will the alliance look like? How will alliance arrangements deliver benefit to the local populations of Harrow, Ealing, Hillingdon and Brent while achieving maximum efficient scale?
- What corporate support services are required and who will host/provide those? What freedoms will be given to procure corporate support services elsewhere?
- Who will own facilities and/or be responsible for lease agreements and costs?
- What choice will Provider Services have to step back from delivering certain clinical services?
- What freedom might it have to develop clinical services into new areas, either within its existing localities or outside?
- What governance arrangements need to be in place and what transitional arrangements need to be in place as the Provider bodies move towards Externalisation?

6.4 Summary

The 2008/09 Operating Plan requires PCTs to separate their core commissioning activities from their provider activities. In this context, the term 'separation' describes a clear delineation of commissioning and provider activities. Whether this separation leads to externalisation is a matter which each PCT Board will determine, although NHS London requirements are clear.

The extent of separation can be described at three levels:

- Arm's length (separate governance arrangements within the PCT)
- Autonomous (own corporate functions within the PCT) and
- Externalised (complete independence from the PCT).

The introduction of the provider sub committee of the PCT Board prevents Brent's Provider Services from becoming a peripheral part of the PCT. Nonetheless, the PCT's strategic focus will be on developing world class commissioning competences. Operational management of services does not feature amongst these.

By allowing the Provider Services Sub-Committee to have an exclusive focus on providing community services provides the space, scope and incentive to develop world class community services, as a suitable analogue to Brent's world class commissioning ambitions.

Creating an APO to manage the delivery of community health services is expected to give rise to benefits for commissioners, for providers of services and, ultimately for users of health services.

Creating an autonomous Provider Services arm will not be a costless exercise. Three types of cost pressure are likely to be introduced: non-recurrent development costs, reallocated and new recurrent revenue costs. Illustrative costs are described within the body of this section.

Brent Provider Services has now completed Module 1 of its provider development programme and needs to determine its support requirements to move firstly to an APO. It will work collaboratively with Ealing, Hillingdon and Harrow PCTs on possible arrangements for an Autonomous Provider Organisation. There are a number of issues that will have to be worked through to achieve this.

7. Conclusions and Recommendations

7.1 Conclusions

The PCT commissioned a review of its provider services at its meeting in November 2007. This was in the context of PCTs needing to separate their commissioning and providing functions, and in particular to gain an understanding of the strengths, weaknesses and business context of particular provider service lines.

The context for PCT provider services has changed since the report was commissioned, in as much as:

1. NHS London has made it clear that it expects provider services to achieve autonomous provider status (APO) as soon after April 2009 as possible.
2. Commissioning organisations are expected to fully externalise their provider arms after APO status is achieved.
3. NHS Brent has entered with partner PCTs in Harrow, Ealing and Hillingdon a project to explore the option of creating a multi-borough APO. The exact terms of reference, governance and timescales for this work is in development.

There are some important findings in the report.

- Financial and activity information on community services is weak and underdeveloped, and this has hampered the completion of the work.
- Although the PCT spends a proportion of its income on community services which is consistent with its peers, it employs less community staff. There is evidence that more Brent resources are tied up in estates and overheads and the model of service is clinic based rather than community based.
- Some of the most important and largest community services do not score well on fitness for purpose. The services that score well tend to be niche or specialist services.

The programme concludes by placing services into four categories. Those are: services to be retained in the long term by provider services as part of its core service portfolio, services which need a focused period of redesign and then re-assessment by commissioners and providers, services to be transferred now to other providers and services that should be discontinued or the PCT's requirements substantially re-framed so that a significantly different service model results.

It is important to note that these are recommendations for discussion, rather the final view of the PCT. While a number of services may, for the provider, be highly attractive to continue to provide, there may be compelling reasons to integrate these services with other providers. Examples may be some children's services and the walk in centre. Integration with another organisation may have greater benefits for patients.

Next Steps

On the basis of this report, the provider arm and commissioners will agree the action needed to ensure:

1. A clear and transparent process is designed leading to recommendations as to which services are continued in the provider portfolio, and which are transferred or re-commissioned.
2. That where services require further development to become fit for purpose there is a clear plan for doing so.
3. That the terms of reference of the provider development board are revised to take into account the completion of the PUK project and the need to incorporate the North West London Provider Alliance.

A report will be made to the next board meeting on how these issues are being taken forward.

7.2 Summary of Detailed Recommendations

Detailed recommendations aimed at developing NHS Brent PCT Provider as a fit for business and fit for purpose organisation have been articulated throughout this report. It is suggested that these recommendations should inform the ongoing Provider Services Development Programme.

Finance

1. Undertake further analysis of financial performance of Provider Services as a whole and individual service lines within the portfolio of services at the end of the year once a 2008/09 actual expenditure is available against the full year budget allocation.
2. Gain a comprehensive understanding of the source and volume of activity attributed to third party income. Allocate relevant income to associated service lines and reassess the potential impact of loss of third party income on individual service lines and Provider Services as a whole.
3. Gain a detailed understanding of the cost profile of Provider Services which should include the reassessment of indirect and direct cost allocation.
4. Gain a detailed understanding of the estate requirements of Provider Services. Make decisions regarding future estate ownership between NHS Brent Provider and Commissioner.
5. Develop an agreed protocol for the allocation of managerial and clinical posts to associated budget codes.

6. Gain a detailed understanding of the staffing costs associated with the delivery of front line services (which includes those staff allocated to the estates team which provide reception and admin duties).
7. Reconcile financial and ESR data of establishment and staff in post and review budget structures to reconcile the cost of establishment for each service.

Information and Performance

8. Improve the quality and completeness of activity data collected. Once completed, undertake further benchmarking work to determine a more accurate cost per contact.
9. Develop infrastructure and systems which will provide the data needed to define the Provider Services as a *fit for purpose* and *fit for business* organization.

Workforce

10. Review the Provider Requirements for workforce information and ensure that full use of ESR is made.
11. Develop a competency based management development training plan for Service Leads and Senior Managers within the Provider Arm based on individual and collective capability development requirements.
12. Review the role of Service Leads to ensure best use of clinical skills are made and ensure that clinical activity is attributed to clinical as opposed to managerial budget codes.
13. Develop a staff communications and engagement strategy to ensure the full engagement of staff in future service changes.
14. Gain and maintain a greater understanding of workforce competencies available within the workforce and the requirements of a future workforce. Develop and implement a Provider Services workforce development strategy.

Quality , Safety and Effectiveness

15. Develop and implement an outcomes framework which facilitates the calculation of cost benefit at individual service level.
16. Assess the impact of the low level of staffing resource on the quality of service delivery.
17. Develop quality plans for each service and the provider as a whole which facilitate the delivery of services which are of optimum quality and to provide a mechanism to evidence achievement and improvements in quality.

18. Ensure practices are in place to attain uniformity in the application of systems and processes which facilitate quality both within and across services.

Commissioning

19. Continue to develop purchaser/provider relationships with all key strategic commissioners and Practice based Commissioners in Brent.
20. Ensure mechanisms are in place for services to systematically obtain an accurate and up-to-date picture of commissioners priorities, intentions and plans and for commissioners to proactively receive information which assures them that services are delivering in line with commissioning requirements.

Business Infrastructure and Support Services

21. Examine Provider Services requirements for support services, determining which of these it needs to host within its own structure (for example, human resources, business planning, client relationship management, and business development capabilities), and which it wishes to commission from external sources.
22. Develop robust corporate support agreements which define the nature and cost of services provided, the outcomes required and measures of the performance achieved.

Provider Development and Marketing

23. Develop robust mechanisms for engaging patients and the public in service evaluation and design and implement across services within the Provider portfolio.
24. Develop mechanisms for seeking the view of provider partners on the quality and effectiveness of Provider services delivery.
25. Attain an in-depth understanding of the characteristics and strengths of potential competitors. Utilize this information to develop the Provider Services marketing strategy.
26. Develop a provider strategic development plan which gives consideration to the future nature and content of the provider portfolio based on the assessment of current capabilities and delivery model. The plan should incorporate short, medium and long term business development opportunities.
27. Ensure strategies to reduce clinical, financial and operational risks identified within individual services are included in service development plans and are prioritised for attention.

28. Consider reviewing the names of some services to facilitate a better understanding of what the service aims to deliver.

END