Code A

6/12/02

Dear Margaret,

I meant to give you the enclosed travel claim form when we met the other day. I also have enclosed a copy of the Community Unit organisational framework document which you might want to share with Mike Taylor as we discussed.

Best wishes

Code A

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH CARE SERVICES

Outline Organisational Framework for the new Unit

CONTEXT

1. The three White Papers will have a significant impact on the range of services currently provided by the new Unit. The next five to ten years will see both challenges to the way in which services have traditionally been delivered, organised and funded, and opportunities to improve the range, flexibility and quality of services and to pilot different ways of meeting individual patient/client need.

2. The Unit will be managing a process of fundamental and wide-ranging change in an environment characterised by:

   2.1 Client needs exceeding available resources with unflagging pressure on both revenue and capital funds.

   2.2 Increasing demand due to demographic and medical technological changes.

   2.3 Political uncertainty.

   2.4 Uncertain timescales and future scenarios.

   2.5 Increasing fragmentation of services with the shift from standard provision by the two statutory agencies to a diversity of provision by a whole range of agencies.

   2.6 Services increasingly focused on, and in support of, primary health care teams.

ISSUES

3. In considering organisational arrangements a number of (overlapping) issues or tensions need to be considered:

Issue	Comments
A strong corporate identity or devolved local identities?	- Unclear how far there is a common "core mission" for the new Unit as a whole. - Need to avoid forcing an artificial corporate identity. - Given the need for local networks (formal and informal) with external agencies, community health care services need a high public relations profile locally. - Possible model of Unit as "holding company" and operational management divisions as "subsidiaries".

Issue	Comments
Priority to links with Acute District General Hospital services or community agencies?	- Both are equally critical in achieving an effective service for many of the Unit's clients, e.g. particularly parents and children, elderly, those with physical handicaps and women of child-bearing age.
Organise on a district care group or local geographical basis?	- Care group option has clear benefits for Health planning, monitoring, etc. but does not reflect that key links with General Practitioners, Social Services, etc. will be at local not district level. - Client-centred service requires a localised sensitive and responsive approach rather than arbitrary care group boundaries. - In longer term, possible hybrid, i.e. care group organisation within each local area.
Specialist or generalist services?	- Important to ensure that services can respond to the White Paper challenge to define and distinguish health and social care, and to ensure a clear specialist focus for health services in the future.
Gradual or radical change?	- Radical option (e.g. restructuring on geographical basis) would mean colossal upheaval, organisational disruption, risk established networks and diversion from key tasks. Need to be very clear benefits to be justified. - Need to ensure that organisation can respond to changing circumstances. - ex-Community Unit only just settling down from community nursing reorganisation.

KEY AIMS

4. The new Unit will have three main overall goals:

4.1 To sustain services and achieve agreed developments during a period of major change.

4.2 To establish a strong organisation able to ensure the effective provision of health care services to the District's population and to establish strong links with both "purchasing" and other "providing" agencies.

4.3 To support staff during the change process and enable them to respond effectively to both the challenges and the opportunities arising from the White Papers.

5. It is important to define the overall organisational framework as quickly as possible so that the "reorganisation" phase can be completed and energy/time/effort focused on the main patient/client related priorities facing the service.

PRINCIPLES

6. The following criteria should be used in designing an organisational framework for the Unit:

6.1 Build on the strengths of the existing organisation.

6.2 Preserve continuity and minimise disruption as far as possible (i.e. evolutionary rather than revolutionary change).

6.3 Facilitate strong local links with General Practitioners, Social Services and other agencies.

6.4 Be based on "whole" services with integral responsibility for quality, financial resources/control, manpower, etc..

6.5 Ensure an effective "interface" with both Acute District General Hospital services and community agencies.

6.6 As "flat" a structure as possible, with maximum delegation within a clear strategic framework and associated objective setting process.

6.7 Specialist functional services in a primarily supportive, enabling, consultancy role.

6.8 Emphasis on individual accountability rather than diffused accountability through groups, committees, etc..

6.9 Ensure financial control is maintained.

6.10 Ensure "management costs" do not increase at the expense of direct patient/client services.

7. Given the scale and pace of change, management arrangements will need to be fluid and able to respond to changing needs and opportunities.

VALUES

8. If the Unit is to operate on a strongly devolved basis it will be important to ensure that it is held together with a strong, shared management culture. This should be characterised by:

8.1 Keeping patient/client related needs to the forefront of the new Unit's agenda.

8.2 Strong commitment to work in genuine partnership with other agencies, with shared ownership of problems/pressure points in the service; a willingness to pool resources where appropriate; an open-ended rather than a defensive relationship.

8.3 A drive for cost-effectiveness in balance with maintaining a quality service, i.e. making every pound count, reviewing current services rigorously to ensure that staff resources are focused on priority needs.

8.4 As "open" as possible an approach to staff, the public, external agencies, etc., sharing information; acknowledging difficulties and shortcomings in services, etc..

8.5 A bottom-up rather than a top-down approach to objective setting and performance review.

8.6 Encouraging staff to innovate and experiment in meeting patient/client needs; a "planned risk taking" rather than "safety at all costs" approach.

8.7 The management process should "role model" the values that practitioners are being encouraged to adopt in direct client contact, e.g. individual worth, choice, respect, dignity, etc..

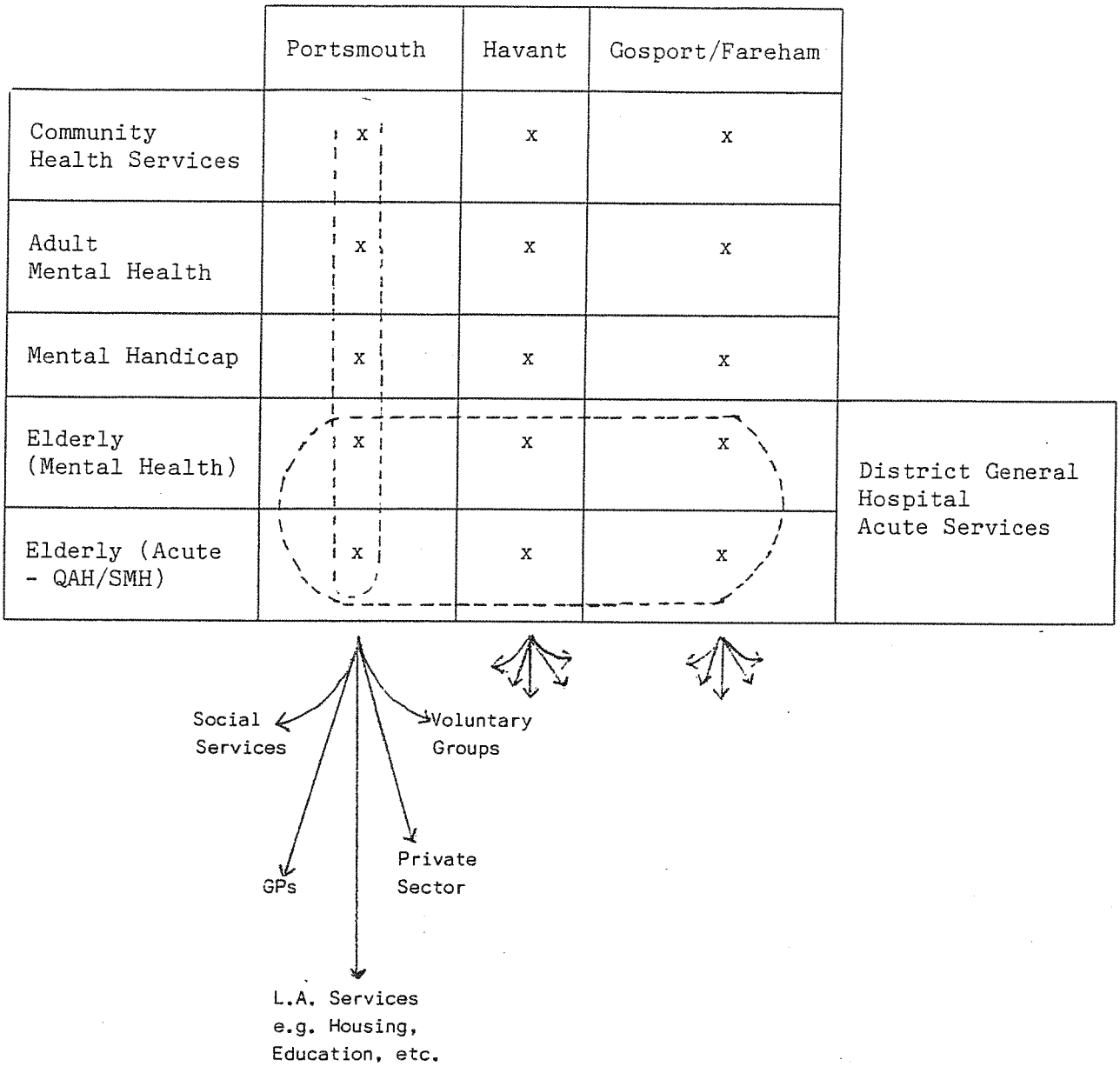
8.8 Need to recognise the level of stress under which staff (practitioners and managers alike) are working; strengthening the support systems available.

PROPOSED FRAMEWORK

9. An outline organisational structure is attached. Once this pattern is accepted in principle then the supporting management and professional advisory arrangements will be progressively defined during the rest of the year.

10. The framework is based on seven strong operational management divisions. The four care group divisions either already have or are moving towards a sub-organisation within each division based on the three key local Areas. This should give the Unit the capacity to modify the organisation naturally as opportunities occur to meet most of the scenarios that can be projected and, in particular, to move towards an integrated Area-based community service.

11. The framework also enables the Unit to manage its two key interfaces in a proactive way. This can be illustrated as shown overleaf:



Each Area will, therefore, have a key group of five managers/"link" people who will be able to co-ordinate liaison with other agencies in a coherent and planned way. Similarly, the two Elderly divisions will be able to ensure strong links with the other Acute services on the District General Hospital sites.

QUALITY

12. Quality is seen as an integral part of the mainstream management process rather than a separate function but needing to be facilitated at all levels in the organisation. In the interim, a Unit Quality Forum is being established with the help of the District Patient Care Adviser so that existing Quality initiatives and activity in the three merged Units are sustained, whilst appropriate arrangements are worked out for the new Unit.

13. Most parts of the Unit have already begun to focus on standards of service, using audit and review techniques of varying kinds. The Quality Forum has a key task in ensuring that this work is shared and co-ordinated.

14. Responses to national medical audit initiative are currently being shared with the Acute Provider Unit. The senior medical staff will be asked to review future arrangements at the time that professional advisory issues are considered (see 16 below).

PROFESSIONAL ADVICE

15. Given the disparate nature of the new Unit it is essential to ensure effective professional advice in each operational management division, with appropriate professional participation in management and planning processes, and the development of stronger links locally with other agencies. This will need to be tackled as a priority within each division.

16. Arrangements for medical advice at divisional and Unit levels need to be finalised with senior medical staff but are expected to include:

16.1 Close links with the District Committee of General Practitioners and the Family Health Service Authority.

16.2 General Practitioner representative on the Unit Management Team.

16.3 Consultant and/or General Practitioner involvement in divisional management groups.

16.4 A review of "Cogwheel" arrangements on the lines of that undertaken in the Acute Provider Unit.

17. Provision of nursing advice at Unit level will be discussed with the chief nurses of the operational management divisions. Possibilities include formalising that group in some way or linking the role with that of Quality Assurance Director.

18. For other professional groups the Unit will look to District Heads of Services/ Advisers as appropriate:

18.1	Speech Therapy	)
18.2	Dental	)
18.3	Chiropody	)
18.4	Psychology	)
18.5	Child Health	) Within the Community Unit
18.6	Health Promotion	)
18.7	Works	)
18.8	Housekeeping	)
18.9	Catering	)
18.10	Dietetics	) Within the Acute Unit
18.11	Control of Infection	)
18.12	Occupational Therapy	) To be determined
18.13	Physiotherapy	)

UNIT MANAGEMENT TEAM

19. Initially a Unit Management Team will be established comprising the Unit General Manager and Deputy, the seven divisional General Managers, five functional Directors and General Practitioner representative.

CONCLUSION

20. The approach outlined above builds on the strengths of the three merging Units, offering a framework within which the new Unit can develop naturally, and flexibility to meet the challenges of the next ten years.