Bath & North East Somerset Council		
MEETING:	COUNCIL	
MEETING DATE:	16th November 2010	**AGENDA ITEM NUMBER**
TITLE:	Community Health and Social Care Services – Future Provision	
WARD:	ALL	
THIS IS A PUBLIC REPORT		

List of attachments to this report:

Appendix 1: Summary of the NHS White Paper: Equity & Excellence: Liberating the NHS (published July 12th 2010).

Appendix 2: Services Currently provided by B&NES Community Health and Social Care Services.

Appendix 3: Transforming Community Services Options Appraisal Update.

Appendix 4: Relative Financial Appraisal – Summary PCT and Council Analysis.

Appendix 5: Proposed Legal Form of the New Organisation – the Options.

Appendix 6: Project Governance Structure.

Appendix 7: Outcomes from the Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010.

1. EXECUTIVE SUMMARY

1.1 The Council and NHS Bath and North East Somerset (the Primary Care Trust or PCT) are committed to working in partnership to provide integrated community health and social care services and to commission health, social care and housing for the benefit of patients, clients and taxpayers.

1.2 In July 2010 the Coalition Government published its NHS White Paper *Equity and* Excellence*: Liberating the NHS.*

1.3 There are three elements of the White Paper that impact on the Council:

- The Council will become responsible for the public health services currently within the PCT. It will also be required to establish a new Partnership Board to take over the statutory function of the Health O&S Committee and to work with partners to shape the local NHS and influence strategic planning.
- Primary Care Trusts (PCTs) will cease to exist from April 2013. Commissioning is currently integrated across health, social care and

housing. The Council will need to decide how best to engage with the new GP Commissioning Consortium, which replaces PCTs, and to determine whether or not to retain the current integrated commissioning arrangements.

- PCTs are required to divest themselves of directly provided community health services by 2011 or to have made substantial progress towards this in the case of a transfer to a new organisation. The current delivery of service is fully integrated across health and social care. If the Council wish to maintain this integration, it will need to work together with the PCT on a revised structure to meet the requirements of the Coalition Government.
- It should also be noted that that there is an agreement in place between the Council and the PCT that covers existing partnership arrangements. Under that agreement it would normally be appropriate for any material change in the arrangements (or any notice of termination) to be given by 12 months notice on 1 April of the relevant year. However, the Council and the PCT are making every effort to progress revised arrangements in accordance with the Coalition Government requirements and without invoking the terms of the agreement. It is important, however, to recognise that there is a formal agreement currently in place to protect all parties.

1.4 This report focuses on the options for the future provision of health and social care services as a consequence of the PCT's requirement to divest themselves of directly provided community health services.

1.5 Further reports will be brought to the Cabinet and the Council (if appropriate) about the transfer of public health responsibilities to the Council, the establishment of a Health and Well Being Board, and future commissioning arrangements in the light of changes in the NHS.

1.6 None of the options for maintaining and developing integrated services are risk free and without cost. Notwithstanding VAT implications the additional cost of the options ranges from £350,000 to ££525,000. However, the taxation issues are different between the options particularly on VAT.

1.7 Given the stage of business planning, this report recommends a commitment to continue work on the Integrated Business Plan to transfer the integrated services to a potential social enterprise. The report also recognises the key role of General Practitioner representatives, as future commissioners, in this further development work and the need for their support for the potential solution.

1.8 However, the Department of Health timescales are very tight and there is a risk that if we do not have a mutually agreed local solution very shortly, then the decision may be taken out of local control. In such event there may need to be further consideration as to the terms of the legal agreement currently in place – see paragraph 1.3 above – and more generally having regard to the objectives of the Coalition Government (including the further

Integration of Health and Social Care and the promotion of social enterprise).

1.9 The tests for the viability of the social enterprise model are set out in the financial implications of the report. However, it should be noted that in terms of even the baseline savings required by the PCT and the Council in future years it can not be assumed that these will all be passed to the provider under any option but that commissioners will also be required to define changes in level of services. It should also be noted that many of these test are common to all the options.

1.10 If the further work proposed shows the financial challenges can be addressed and that General Practitioner representatives and SHA support the proposal, the report proposes the Council delegate authority to the four Group Leaders to implement the option in consultation with the relevant officers, Cabinet Member and the Chair of the Healthier Communities and Older People Overview and Scrutiny Panel.

1.11 Should this further work conclude that the financial challenges of a potential social enterprise cannot be addressed or if there is insufficient support from General Practitioner representatives, a further report will be brought to the Council by the Chief Executive.

1.12 The report also outlines the organisational options of a potential social enterprise, including the broad principles to be used in developing the governance arrangements for the social enterprise.

1.13 The NHS Bath and North East Somerset Board will consider these issues in a similar report at its meeting on 18th November 2010.

1.14 Finally, the report explains the project governance arrangements and the next steps in implementation should the Council and the PCT Board agree the way forward.

2. THE ISSUE

2.1 The Council and NHS Bath and North East Somerset are committed to working in partnership to provide integrated community health and social care services and to commission health, social care and housing for the benefit of patients, service users and taxpayers.

2.2 The NHS will undergo radical change over the next 3-5 years as a result of the Coalition Government's plans for the NHS as set out in its NHS White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health, July 2010). This will have implications for the Council and the NHS in three main areas:

- The new statutory functions that transfer from the NHS to the Council relating to public health and health improvement, including new powers to influence and help to shape the local NHS and its

longer term strategic planning. This includes a duty to promote the integration of health and social care services. The Council will be required to take over the public health services currently within the PCT and to establish a new Health and Well-Being Board, which amongst other duties takes over the Council's statutory function of the health scrutiny. These new statutory Board arrangements will also need to consider the inclusion of Children's Services and the need for a clinical component. Further reports will be brought forward on these issues.

- The implications of the dissolution of PCTs on the current integrated commissioning of adult health, social care and housing services and children's health and social care commissioning. Further reports will be brought forward on this issue.
- The implications of the directive to PCTs to divest themselves of direct provision of community health care. If the benefits of service integration are to be maintained and developed further then the implications for the relevant Council services need to be considered and decided upon.

2.3 Appendix 1 contains a summary of the White Paper for Members information.

2.4 Appendix 2 to this report contains the services currently delivered by the integrated provider (Community Health and Social Care Services) for members' information and which are in scope for any transfer to a social enterprise should this be the chosen way forward. The scope of services and staff to transfer will be subject to change at the margins as the implementation develops. The gross value of these services (excluding the Council's placement budget) is circa £50 million (£40 million net) based on the current configuration of support services. There will also be further work required on appropriate elements of support services to transfer.

2.5 Considerable work has taken place within B&NES to create the integrated health and social care services over a number of years. This model of care has improved the experience of people using the services, made their care safer, more effective and more efficient.

2.6 Examples of the benefits of integration to patients/service users include:

- Receiving services closer to home through local community teams.
- A single access point for health and social care services.
- People receiving a single assessment and not asked for information twice.
- Complex problems involving a combination of agencies are resolved quicker benefiting both service users and families.
- More personalised care packages spanning health and social care.
- People staying at home longer and entering residential and nursing care homes at a later stage.

- Increased number of direct admissions to community hospitals avoiding admission to acute hospitals.
- Reduced delayed transfers of care and lengths of stay. For example, from April 2009 to May 2010, the average length-of-stay in Paulton and St Martin's hospitals reduced from an average of 30 to an average of 20 days. Lengths of stay in the Royal United Hospital Bath have also reduced as have the number of people whose discharge home is delayed.
- Fewer transfers from community hospitals into acute hospital care.
- Joined-up end of life care.
- Joined-up, local response in adverse weather, sustaining people at home.

2.7 Examples of the organisational benefits of integration include:

- Collaborative joint working and a whole system approach avoiding cost shifting between health and social care, and as a result making the best use of public resources.
- More effective use of resources/increased capacity in the community through integrated workforce development and skills mix.
- Intelligent systems enabling identification of multiple safeguarding alerts and early joint response.

2.8 In addition, the integration of these services present further opportunities to maintain or to improve services in the future, which will be more difficult to achieve if the services have to be separated. These include:

- Further development/enhancement of the three locality Community Teams aimed at avoiding attendances and admissions to hospital where people could be cared for at home and in the community, for example:
  - Extending the Access Service to 7 days a week – recent analysis of weekend Accident & Emergency attendances at the RUH suggests that an average of 4-5 admissions could be prevented each weekend.
  - 7-day therapy service in community hospitals which will further contribute to admission avoidance, reduced length of acute hospital stay through early supported discharge, and care closer to home.
  - Development of the Community Therapy Service to reduce hospital admissions for patients requiring intravenous antibiotic therapy. Based on a best practice model, 275 admissions per annum may be avoided. This will also expedite the discharge of approximately 4 patients per week. The objective is to reduce length of stay in the acute hospital setting by an average of 4.5 days.

- Reducing the number of people who die in hospital following an emergency admission. A number of service changes are being implemented during 2010/11 with the objective of reducing the number of people aged more than 65 dying in hospital by 80 per year. This service change represents a significant quality improvement for service users and their carers, the greater proportion of whom would prefer to manage their end of life care at home with appropriate support rather than to die in hospital.
- Integration of community learning difficulties team to mainstream provision enabling greater social inclusion and improving access to health services for people with learning difficulties.
- Realising the opportunities to simplify systems and introduce common procedures to increase efficiency to better meet the existing and forthcoming financial challenges.

2.9 While it is recognised that some of these benefits could be achieved through other means, building upon the already strong partnership working through *full* organisational integration may allow these benefits to be achieved quicker.

2.10 Given the challenging financial climate, pressures from demographic changes and the new duty for the Council to promote the integration of health and social care services, the benefits to patients, service users and the ability to use resources more effectively in the medium to longer term cannot be ignored or easily foregone. However, whatever option is ultimately decided upon the solution will have to be based on a balance of efficiency savings and service levels between the commissioners of services and any provider.

2.11 An independent assessment of the costs and benefits of integrating health and social care, which reviewed over 80 studies of service integration, concluded that: "… meeting people's needs with a preventative and integrated approach to health and social care can create efficiencies and savings. However, future studies do need to consider the long-term financial benefits. Many of the studies that concluded that integrated care was not cost effective were conducted over short time periods, and many of the benefits will accrue as individuals remain independent well into the future. In particular, those integrated services that have a focus on early intervention are designed to prevent needs escalating in years to come, and therefore, the real benefits will be realised over time." (*Benefits Realisation: Assessing the Evidence for the Cost Benefit and Cost Effectiveness of Integrated Social Care, Turning Point, February 2010*).

2.12 The local delivery of services in this integrated form makes the need for NHS B&NES to divest itself of its delivery arm more complex. The agenda is mandatory for PCTs, but the Council will need to consider whether the benefits of integration in the medium to longer term outweigh any risks that may be associated with the transfer.

2.13 If the Council wishes to maintain the benefits of service integration, it will need to decide how its own social care and housing services will be delivered as a result of changes in the NHS. There is, in effect, no "do nothing" option as from 2013 the PCT will cease to exist and current community health services, with which the Council's services are integrated, will no longer be provided by the PCT. The separation of services may incur additional costs, including the separation of management and foregoing other economies of scale. Indeed there may be serious financial challenges for the Council stand-alone Adult Social Care provider given the outlook for local government funding and the demographic challenge.

2.14 It should also be recognised that the Council will be undergoing an extensive change programme, which will increasingly see it focussing on commissioning and a mixed economy of service provision in response to the impact of a broad range of changes at a national and local level and the wider financial pressures. The changes in health and social care (and with regard to its Local Education Authority function in the light of Academies etc.) will have an impact on this change programme and the future shape of the Council.

2.15 This report focuses on the choices and considerations for the Council in relation to its Adult Social Care Services, given the requirement on NHS Bath and North East Somerset to divest itself of directly provided community health services. Housing services are not included as these are exclusively commissioner activities and will remain with the Council, albeit delivered hopefully through an integrated commissioning function with the PCT. The options for future commissioning arrangements in the transition to the new GP Commissioning Consortium will be the subject of future reports to the Council.

2.16 In considering its decision, the Council (and the NHS Bath And North East Somerset Board) will need to weigh up and take into account the following considerations:

- The extent to which the proposals meet the four generic tests of service re-configuration that the NHS has been required to apply since July 2010:
  - Support from GP Commissioners
  - Strong public / patient engagement
  - Clarity about the evidence base for the change
  - Consistency with current and prospective patient choice
- Strategic fit with the future direction of the Council, including the Council's wish to maintain and build on the benefits of integration and whether the proposed option could deliver the key strategic objectives of the Partnership especially:
  - Continued and greater integration of services at a delivery and organisational level

  - Meeting the personalisation agenda
  - Delivering services closer to home and outside of acute hospitals

- Efficiency in terms of demonstrating added value to existing delivery of services in relation to cost savings and value for money.
- Deliverability within the timescales set by the Department of Health (or shortly thereafter) without compromising significantly the Council's objectives or risk profile.
- Acceptability to the Partnership as a whole, to staff, wider stakeholders and the public.
- Robust governance arrangements to ensure patient and service user safety, effective performance and the effective use significant public funds.
- A focus on quality and improvement.
- Initial affordability challenges including estates, pensions, taxation, pay harmonisation, working capital and budgetary constraints.
- Sustainability of the solution in terms of flexibility to respond to the changing environment and be financially viable and sustainable over many years.

2.17 These criteria have been used to identify the advantages and disadvantages of the options and an initial qualitative and quantitative analysis of the options.

3. RECOMMENDATIONS

The Council is recommended to:

3.1 Indicate its commitment to a direction of travel that aims to transfer integrated community health and social care services into a potential social enterprise subject to the approval of the NHS Bath and North East Somerset Board at its meeting on 18th November 2010.

3.2 Recognise the key role of General Practitioner representatives as future Commissioners in developing the proposal.

3.3 Note that the initial high level Integrated Business Plan will be developed further over the next two months to test the viability of the social enterprise.

3.4 Delegate authority to the to the Chief Executive with the agreement of the Leader of the Council and the Leader of the Liberal Democrat Group, in consultation with the Labour and Independent Group Leaders, the Cabinet Member for Adult Social Care and Housing, the Chair of the Healthier Communities and Older People Overview and Scrutiny Panel, the Monitoring Officer, and the Council's section 151 Officer, to:

3.4.1 Take all steps necessary or incidental to work with NHS Bath and North East Somerset and General Practitioner Commissioning representatives to develop the potential social enterprise option.

3.4.2 Implement the option including the organisational form of the potential social enterprise and the development and award of the contracts relevant to Council services, subject to the detailed Integrated Business Plan demonstrating to his satisfaction the viability of the new social enterprise within budget provision and support for the option being agreed with the General Practitioner Commissioning representatives and the Strategic Health Authority.

3.5 Instruct the Chief Executive to produce a further report should, in his opinion after taking relevant advice, he conclude the financial challenges as expressed in the Financial Implications to this report cannot be met or if sufficient agreement with General Practitioner Commissioning representatives and the Strategic Health Authority is not achieved.

3.6 Agree that the proposed option is subject to proportionate due diligence prior to any transfer of services.

3.7 Note that the Integrated Business Plan shall be submitted formally to the NHS South West, the Strategic Health Authority, following the meeting of the NHS Bath and North East Somerset Board, and will be subject to further development over the next two months.

3.8 Note the project's governance arrangements, next steps, costs, timetable and the high-level outline terms of the pooled project budget between the Council and NHS Bath and North East Somerset.

4. CORPORATE PRIORITIES

4.1 The NHS White Paper creates a number of new duties for the Council, including a duty on the Council to encourage integration of health services with social care services.

4.2 The proposals therefore directly impact on the following corporate priorities:

- Promoting the independence of older people.
- Improving life chances of disadvantaged teenagers and young people.

5. THE REPORT

Introduction

5.1 This report is divided into five sections supported by detailed Appendices:

- A chronology of events to date.
- The options appraisal, including a risk assessment (Appendix 3).
- The proposed legal form [of the new organisation] (Appendix 4).

- An outline of the project arrangements, governance and budget (Appendix 5).
- An outline of the next steps.

Chronology of Events to Date

5.2 The requirement for the PCT to divest itself of its directly provided services spans both the previous Government and the current Coalition Government.

5.3 The Department of Health document Transforming Community Services (DH Jan 2009) and NHS Operating Framework 2010-11 (February 2010) required PCTs to divest themselves of their directly provided community health services by April 2011.

5.4 The Coalition Government's Revised NHS Operating Framework 2010-11 (June 2009) reaffirmed this policy direction. The White Paper subsequently introduced the intent to dissolve PCTs by 2013 and therefore to proceed with the provider divestment programme, even if this meant transfer to other organisations while a medium to long term solution is developed.

5.5 The revised operating framework stated that, "proposals should be capable of being implemented, or substantial progress made towards implementation, by April 2011."

5.6 Within this context, the chronology of events to date is shown in the table.

Date	Event	Outcome
March 2010	Response to the original NHS Operating Framework requirement for divestment.	NHS B&NES in consultation with B&NES Council submitted an options appraisal. This suggested that the Social Enterprise model is one that the Council and the PCT would like to explore further and that a detailed business case would be developed prior to any final decisions being taken. There was no opportunity for public involvement at that stage given the impending election. NHS South West (the Strategic Health Authority) approved this proposal in principle.
June 2010	Revision of the NHS Operating Framework 2010-11 by the Coalition Government.	Reaffirmation of the Coalition Government's intentions to continue with the divestment of directly provided PCT community health services.
July 2010	A work plan required for submission to NHS South	A work plan was submitted on time and

Date	Event	Outcome
	West (the Strategic Health Authority)	evaluated by NHS South West positively.
August 2010	A Commissioning Case for Change required for submission to NHS South West. The Case for Change sets out the financial, economic, clinical case for changing the current arrangements, including the options appraisal.	The Commissioning Case for Change was prepared in late August and submitted on time and evaluated by NHS South West positively for recommendation to the Department of Health. While the SHA/DH approval is in relation to NHS services the Case for Change included the strategic reasons for maintaining the integration of services.
September 2010	NHS Contracting Intentions, required for submission to NHS South West. The Contracting Intentions set out in broad terms the services to be provided, the resources available and other potential contracting issues.	Submitted on time and evaluated by NHS South West positively for recommendation to the Department of Health.
October 2010	Integrated Business Plan for the proposed provider required for submission to NHS South West.	It was agreed with NHS South West that no formal evaluation of the Integrated Business Plan would start until the Council and the PCT Board agreed the recommended option. A work in progress draft of the Integrated Business Plan was sent to NHS South West on 31 October to assure the SHA that progress was being made.
November 2010	The Council and the PCT Board to decide on the way ahead.	To be determined by the Council and the PCT Board

5.7 It can be seen from the chronology that the timescales are challenging and determined by the Department of Health nationally for the NHS services but not for the Council services.

5.8 NHS South West, in supporting the proposal, has been supportive in adapting the national deadlines as much as it can in recognition of the novel and complex nature of the proposal to explore the potential of a social enterprise for a joint provider of services.

5.9 In the case of a new organisational form being proposed, NHS South West has clarified "substantial progress" by April 2011 to be:

- Establishing a viable and sustainable business case for the provider organisation
- Establishing the provider organisation as a legal entity in a pre-trading form, including the appointment of the Board and the Leadership Team

5.10 If the Council is committed to maintaining and building on the benefits of integration it will need to work within the Partnership to help ensure that NHS B&NES meets its mandatory deadlines as set by the Coalition Government's requirements. NHS B&NES and the SHA will similarly need to be responsive to the Council's objectives and statutory responsibilities and have regard to existing agreements in place as between the parties.

The Scope of the Services to Potentially Transfer (Appendix 2)

5.11 The Transforming Community Services Contracting Intentions set out at a high level the contracting intentions for the new provider and these will be developed further with the integral involvement of General Practitioner representatives.

5.12 However, there are certain issues that have to be addressed in advance of any transfer to define the broad scope of the services to transfer. These include:

- Resources would need to be retained to ensure the Council's statutory safeguarding duties and its statutory responsibilities for assessment in any option that transfers responsibility to an NHS body or a new organisation such as a social enterprise. An initial assessment indicates that 7.4 full time equivalent posts will need to be retained by the Council and the PCT to cover these functions of which 1.9 full time equivalent posts are additional. The latter have been reflected in the relative financial appraisal and, at present, in the initial Integrated Business Plan.
- The purchasing budget for placements (£23m net), which is used to purchase other services from other providers. It is proposed that this is currently retained under any option that transfers responsibility to an NHS body or a new organisation such as a social enterprise. This is because the placements budget is a high risk budget over which any other organisational form is not best placed to manage the risk. However, this could be examined further on an appropriate risk share basis.
- Income collection – it is currently being assumed that income collection remains a risk for the Council and that the Council will continue to manage income collection. However, other arrangements will be explored for any new provider to share this risk and to incentivise collection.
- Some elements of support services (including finance, ICT, HR,

Estates, and Facilities Management) will need to be retained by the Council and the PCT. This is a complex area which will need detailed work both in terms of transitional arrangements and longer term solutions in order to ensure the optimal structure as between the Council, PCT and the new provider which is also consistent with the requirements of the Transfer of Undertakings Protection of Employment (TUPE) legislation. The key principles contained in the commissioning intentions are:

- That the core business of the provider is not the provision of support services to third parties. The implications for commissioning bodies will need to be examined separately for both the PCT and the Council in terms of longer term provision of support services.
- That wherever possible support services will be separated subject to any national initiative to set up shared services.
- The assignment of staff to the provider under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) as amended or replaced or any other regulations or UK legislation implementing the Acquired Rights Directive with the necessary adjustments to the contract values.
- That wherever possible, duties of staff where they are not wholly engaged in the activities of the provider will, in consultation with those staff, be adjusted to minimise the financial impact on the provider, the Council and NHS B&NES.
- It is acknowledged that Information Management & Technology is very complex. It is likely that the provider will require the use of the Council's and NHS B&NES ICT infrastructure. It is also likely that CHSCS will be required to use the Council's and NHS B&NES main service support applications. It is also likely that the provider may require certain support applications (e.g. general ledger). The initial thinking is in terms of the infrastructure and major applications remaining with the Commissioners with priced service specifications being developed and finalised by December 2010/January 2011. The provider will, over time, expect autonomy in provision of support services. There may be interim arrangements for an agreed period and the Council (and/or the PCT/NHS) may want to put together an 'offer' to the provider for the longer term if this represented commercial sense to both parties.
- That wherever there are contractual arrangements with other third party suppliers of support services these contracts will pass to the provider as another party to those arrangements up to but not exceeding the main contract period. If for some reason this is not acceptable the issue will be discussed with the provider and the third party to reach a solution that

minimises the financial detriment between the affected parties.

- CHSCS is also expected to provide adequately for support services to meet its other governance and statutory responsibilities. The Council and NHS B&NES will consider adjustments to the contract values where they can identify discrete budgets or where there is a subsequent cash reduction in their costs or charges from others.
- That wherever the provider indicates the need for transitional arrangements the commissioners shall ensure their best endeavours to provide for these transitional needs for a period of one year or at most the length of the main contract(s).

- The Council and the PCT will retain the ownership of their respective relevant property estate with arrangements put in place for the use of the estate by the provider.

5.13 These will be developed in detail as part of the project going forward.

The Options Appraisal Update (Appendix 3)

5.14 The original options appraisal, carried out in March 2010 included 11 options. Despite the challenging timetable, the original options appraisal of March 2010 has been re-evaluated to take into account changes since the General Election in May 2010 and the publication of the NHS White Paper in July 2010.

5.15 The reappraisal of the options is considering the original 11 options with the following four exception(s):

- The "remain as is" option; which is not now available due to the NHS White Paper policy to abolish Primary Care Trusts from 2013.
- The Community Foundation Trust option as the deadline for this option has elapsed; it is unlikely to be deliverable within the timescales of the Department of Health and is unlikely to receive the support of the Strategic Health Authority.
- Integration with other PCTs' provider services again because of the NHS White Paper policy to abolish Primary Care Trusts from 2013 and for reasons of deliverability as neighbouring PCT Providers will all be going through similar changes.
- The managed dispersal of services, whereby various elements of services are transferred to other bodies (the Council, the Royal United Hospital NHS Trust, the Avon and Wiltshire Mental Health Partnership NHS Trust and other independent sector providers) as this is inconsistent with the strategic direction of the Commissioning Case for Change which puts integration of services at the heart of service delivery.

5.16 An additional option was introduced into the appraisal. This option is a joint venture with an established provider, as a partner may bring the business

infrastructure and expertise to run a new organisation and may be able to supply working capital.

5.17 The options reappraisal therefore focuses on eight long listed options which are summarised below:

- Standalone community services provider: Social Enterprise
- Operate at “arms-length” within local authority
- Integration with Royal United Hospital NHS Trust (vertical integration)
- Integration with the Avon and Wiltshire Mental Health Partnership NHS Trust
- Integration with GP Services
- Integration with Charity/Third Sector
- Transfer to the private sector
- A joint venture between the private sector and the Council

5.18 The qualitative analysis of the options in terms of the advantages and disadvantages is shown at Appendix 3, which also describes the criteria and options in more detail.

5.19 The criteria have been used in drawing up an initial short list of options to explore further.

5.20 Certain options are difficult to deliver in the timescales required for the NHS, whether this be for integrated services or just health services alone These are integration with GP Services, integration with Charity/Third Sector, transfer to the private sector, and a joint venture between the private sector and the Council cannot be achieved within the timetable for the divestment of health services as under these options a tendering process will need to be established which at best would take 9-12 months to conclude, excluding a transition period for the transfer to occur.

5.21 On the basis of this, a short list of four options was drawn up which are:

- Standalone community services provider: Social Enterprise.
- Operate at “arms-length” within local authority.
- Integration with the Royal United Hospital NHS Trust.
- Integration with the Avon and Wiltshire Mental Health Partnership NHS Trust.

5.22 For the purpose of the relative financial appraisal the NHS Trust options have been grouped together as they are similar in nature for the purposes of the appraisal. It is also likely that all of these Trusts would need to be invited to express an interest and submit proposals.

5.23 A relative financial appraisal has been carried out for the short list of options. This is summarised in the table below and shows the relative financial challenges under each of the options in total (for the Council and PCT).

	Averaged Annual Costs		
	Social Enterprise £'000	**NHS £'000**	**Council £'000**
VAT	1,072	473	0
Operating Costs			
Pensions	87	234	0
Corporate Governance	315	50	100
IT/Licences	0	0	250
Corporation Tax	0	0	0
Delegations	80	50	30
Working Capital Costs	10	0	0
Funding Opportunity Cost	16	16	0
Set Up Costs Funding	17	0	0
	525	350	380
Total VAT and Operating Costs	1,597	823	380
One-Off Costs			
Set Up	1,000	600	350
Social Enterprise Grant	-230	0	0
Existing Budget	-300	-300	-300
	470	300	50

5.24 Appendix 4 shows a breakdown of the table above in terms of the costs arising from the Council and the PCT. It should be noted that these are annual average costs and the profile of costs may differ over the years. In the analysis of costs between the PCT and the Council, costs have been attributed where possible but other costs (for example, set up costs have been allocated on an equal basis between the PCT and the Council).

5.25 It can be seen that the relative costs of the options are incurred in different ways across the options. In broad terms, excluding the VAT issue, each option is broadly at the same order of additional operating costs in the range of £350,000 to £500,000.

5.26 However, the VAT issue is a challenge and this is, from initial research, a significant issue for all proposals to move to social enterprises whether this is for NHS services alone or integrated service transfers. While the profile of this issue is being raised at a national level the resolution of the issue remains a considerable risk.

5.27 At worst the social enterprise or an NHS Trust will need to make savings equivalent to the additional VAT liability and/or there will need to be discussions with commissioners about the quantity and quality of services that could be delivered for the resources available from the commissioners. The VAT issue also depends on the extent to which the liability can be reduced through different ways of working and the division of support services, which requires much more work.

5.28 It should also be noted that the one off costs differ between the options and the social enterprise option assumes a grant/loan from the Social Enterprise Investment Fund in line with a recent award for a similar project. However, this grant/loan has not been applied for at this stage and may be a significant risk.

5.29 The additional costs identified in the relative financial appraisal have been reflected in the initial high-level Integrated Business Plan. This leaves a significant gap in the financial position of the any potential social enterprise. However, given the stage of the business planning, considerably more work needs to be done to identify how these additional costs could be met through efficiency or service reconfiguration or through discussions with the commissioners about service levels and resources.

5.30 To a varying extent this is a common issue with all the options and any solution will require a commercial approach to demand, level of service and achievable efficiencies. In other words, the financial challenges cannot be totally passed to the provider.

An Initial High Level Business Plan for a New Organisation

5.31 In order to provide further information to the Council and the PCT Board and to meet the requirements of NHS South West, a high level initial Integrated Business Plan has also been prepared to further test whether the recommended option is viable.

5.32 B&NES PCT and Council formed a partnership in April 2009 for the delivery of community and social care services. Under the terms of the partnership there was a number of joint posts and a pooling of budgets however legal separation was not carried out. The partnership produced some financial information on the combined entity but this did not include full statutory accounts As such there is some financial information on the merged entity from this point.

5.33 The following table summarises the historic performance of the partnership:

	2009/10 £'000	2010/11 £'000	2010/11 £'000 (5 Months Actual)
Income	87,244	86,690	38,586
Expenditure			
Pay	(40,573)	(39,975)	(16,819)
Non Pay	(46,370)	(46,402)	(21,200)
Operating Surplus	301	313	567

5.34 The table shows that BANES CH&SCS delivered a small operating surplus before depreciation in 2009-100 and is targeting a small surplus in 2010-11 despite very limited growth in revenues.

5.35 The potential social enterprise has been modelled in terms of its future financial performance using a long-term financial model (LTFM) developed in partnership with a private sector organisation. The LTFM is informed by historical trends and takes account of guidance on future levels of inflation, tariff uplift and savings requirements, as well as adjusting for known business changes agreed locally and resulting from the move to a Social Enterprise (SE).

5.36 The base case (most likely case) shows that in order for the potential social enterprise to operate in the market viably, it will need to deliver savings over and above those currently agreed with NHS and Council to fund the additional costs relating to its formation and operation, some of which relate to the diseconomies of scale, and some relating to the organisational form that the entity is moving to (such as VAT and pension implications). The base case assumes that these additional costs amount to £1.5 million per annum from 2011/12, and that additional savings to cover this cost will be found.

5.37 These assumptions are still subject to final clarification. It is also the case with the social enterprise option as well as other options that there will need to be further negotiations between any provider and commissioners about what is achievable in terms of service standards and efficiencies within the total sum available to commissioners.

5.38 It is recognised that more work needs to be done to the Integrated Business Plan to ensure the proposal is viable and that this work needs to be undertaken with GP Commissioning representatives.

5.39 The initial work shows that the social enterprise option will require the following level of savings to meet the PCT and Council's financial targets and the additional costs of a social enterprise, including generating a small but increasing surplus each year to underpin its financial stability.

	2011-12 (full year) £'000	**2012-13 £'000**	**2013-14 £'000**	**2014-15 £'000**	**2015-16 £'000**
Savings required to meet PCT/Council financial plan Targets (common to all options)	2,900	2,834	810	1,237	1,242
Further savings/mitigations required for a potential social enterprise	1,772	(94)	21	28	45
Total	4,672	2,740	831	1,265	1,287

5.40 The key assumptions are as follows:

- A baseline contract for services provided by NHS B&NES and the Council. The contract will cover a 3-5-year period and should be co-terminus between the PCT and the Council. These contract periods exclude contract periods for support services, which will be dealt with differently.
- Baseline service contract revenues show a reduction on the current Partnerships revenues due to the exclusion of certain services. It has been assumed that the "Purchasing Budget" and "Client Income" will be retained by the Commissioners. The net impact of this is to reduce the revenues by circa £30 million per annum. The financial value of the Council and PCT services are based on the current levels after adjusting for inflation, savings targets from the NHS and performance incentives.
- The generation of surpluses, which if retained would amount to a cumulative reserve of approximately £2m before tax either to be retained for financial stability or a portion to be reinvested in services if this is appropriate.
- The PCT budget is uplifted by 2.5% inflation and 1.5% for quality and innovation payments under the NHS' Commissioning for Quality and Innovation payment framework (CQUIN) in 2011-12 to 2013-14 but also include saving requirements of 4% per annum for each of these years under the NHS Quality, Innovation, Productivity and Prevention (QIPP). The model assumes a net increase of 1% in PCT revenues in 2014-15 and 2015-16.

- It has been assumed that Council revenues will decrease in 2011-12 and 2013-14 in line with agreed savings Council targets of £0.8 million and £0.4 million respectively. This does not include the stretch targets for savings within the Council. There is an assumption that revenues will continue to decrease in the last two years of the plan which will require negotiation with the provider about what is achievable within the commissioners' available resources.
- The Council and PCT revenue assumptions are in line with discussions with Commissioners.
- Third party income (mainly other PCTs) will remain static in 2011-12 to 2013-14 and then increase by 1% in 2014-15 to 2015-16. Most of this revenue is on short-term contracts with 6 month notice periods, although on one contract a longer period has been secured.
- Pensions contributions for NHS staff remain at 14% subject to a Direction Order, Council staff employer contributions will increase by 2.5% as a result of admitted body status in relation to future deficits. This also assumes there is no requirement for a bond. Finally the model assumes a reduced employer contribution of 10% to employees' pensions although this may also be incorporated with other flexible employee packages which will be at the discretion of the social enterprise.
- Non-pay inflation is modelled at 2.5% per annum. It is recognised that certain costs e.g. heat, light and power are likely to increase at a higher rate. It has been assumed that these cost increases can be absorbed by savings in other areas.
- Pay inflation will be zero in first three years of the business plan and 1% for the last two years of the business plan. This headline inflation figure covers both pay awards and incremental drift and is the same for both PCT and Council transferring staff;

5.41 These variables are used in the LTFM to extrapolate income and expenditure through to 2015/16 and produce an Income & Expenditure (I&E) plan for each of the next five years.

5.42 The LTFM assumes a number of changes to costs and income. These business changes are contained within the LTFM, and the key assumptions which underpin each of the Business Change schemes are:

- Business Change 1 (Revenues) – As noted previously, a number of functions currently undertaken by the Partnership will not transfer to the SE. These include the Purchasing Budget and Client Income. The net impact of these is to reduce revenues and costs by circa £30 million.
- Business Change 2 (New Social Enterprise Structure) – The SE is a different form to the current Partnership and this gives rise to a number of cost differentials. These include different management

and Board structures, increased audit and professional fees and increased insurance costs etc. The annual impact of this is circa £0.4 million. It is difficult to assess the costs including, if any, of the governance costs of a transfer to the NHS so this is currently not included in the relative financial appraisal.

- Business Change 3 (VAT) - Both the Council and NHS enjoy special rules with respect to VAT recovery. For VAT purposes the SE is considered a commercial entity and therefore will not qualify for these special reliefs. As a result it will be able to recover less VAT on purchased services than the current Partnership model. The annual impact of this is circa £1 million.
- Business Change 4 (Pensions) - The LTFM assumes that legacy Council and PCT staff will be able to retain membership of their respective pension schemes; the NHS through the SE being granted "Direction Status" and the Council by having "Associated Status". However the consequence of this is that new staff will not be eligible to join either of the legacy schemes. It has been assumed that the SE will establish a new defined contribution scheme for new staff. The LTFM assumes that employer contribution to the new scheme will be lower than the current Council and PCT employer contributions. However, it should be noted that if recruitment proves difficult, the SE may need to put in place a pension scheme that is equivalent to the NHS/Council Pension scheme. The LTFM does not include provision for such a cost. The LTFM assumes that the contributions payable to the Council scheme will increase. The net impact of the Pension Scheme changes is to increase annual costs in 2011-12 by £0.2 million reducing to a saving of £0.05 million by 2015-16.
- Business Change 5 (SE Savings) – Business changes 2 to 4 and 8 will result in increased costs to the SE. The LTFM assumes that the SE will be able to deliver additional cost savings over and above those already identified by PCT and Council Commissioners (see below) to offset these cost increase and deliver a small surplus to the SE.
- Business Change 6 (QIPP Workforce) – There is a requirement for the PCT Provider Services to achieve a 40% reduction in management costs. This amounts to savings of £363k in 2011-12 and a further saving of £153k in 2012-13. The LTFP assumes the 2011-12 savings will be achieved by the Partnership prior to the transfer to the SE in October 2011. The SE will need to deliver the 2012-13 target. There is no redundancy provision in the LTFM associated with this.
- Business Change 7 (CRES/PCT Savings) – The current Partnership is committed to deliver CRES savings of £0.9 million in 2011-12 and 2012-13. The LTFM assumes that the Partnership is able to identify the 2011-12 prior to the transition to the SE. The SE will need to deliver the 2012-13 and 2013-14 savings of £0.9 million in each year. The section below considers the savings initiatives currently

being undertaken by the Partnership and initiatives to be undertaken by the SE.

- Business Change 8 (Council Savings) - The current Partnership is committed to deliver Council savings of £0.8 million in 2011-12 and £0.4 million 2011-13. The LTFM assumes that the Partnership is able to identify the savings to deliver the 2011-12 target prior to transfer. The SE will need to deliver the 2012-13 target. The section below considers the savings initiatives currently being undertaken by the Partnership and initiatives to be undertaken by the SE.
- Business Change 9 (Transition Costs) – This business change reflects the increased costs in 2010/11 and 2011/12 of going through transition. A total cost of £1million has been identified. The LTFM model assumes that £0.4 million of this will be met from existing Council and PCT budget allocations for 2010/11, receipt of a Social Enterprise Investment Fund (SEIF) Grant of £0.23 million and a commercial loan of £0.37 million. If the SE is not successful in its SEIF grant application and/or seeking a commercial loan then the funding pressures on the SE will increase.
- Business Change 10 (Redundancy) – The savings requirements of the LTFM will result in a reduction in headcount. The LTFM does not contain any provision for redundancy costs. The LTDM assumes that all the redundancies required to deliver the 2011-12 savings will be implemented prior to the transfer to the SE and any share of redundancy costs required to be met by the current joint provider will be met through savings agreed by the current commissioners and the current provider, including any changes in service provision. It has been further assumed that redundancy costs relating to headcount reductions to deliver the 2012-13 savings will be covered by the PCT Commissioners based on guidance from the Strategic Health Authority. In relation to the Council the assumptions for 2012-13 are similar to 2011-12, that is, that any share of redundancy costs required to be met by the current joint provider will be met through savings agreed by the current commissioners and the current provider, including any changes in service provision. The LTFM assumes that any subsequent redundancy costs associated with Commissioner agreed changes in the service delivery model will be covered by a risk share agreement with Commissioners, based on the services to be delivered within commissioning budgets. This will need further work to ensure any arrangements are within NHS rules and fair in terms of risk share from the Council's point of view.
- Business Change 11 (Facilities) – The LTFM model assumes that all the facilities used in the delivery of the services will be retained by the Commissioners with the SE granted use of the facilities. The LTFM also assumes that the Commissioners will retain responsibility for repairs and maintenance of the facilities. The

LTFM assumes that use of premises will be cost neutral. Facilities are subject to a detailed work stream.

- Business Change 12 (IM&T) - The LTFM model assumes that all the IM&T equipment used in the delivery of the services will be retained by the Commissioners – the Council with the SE granted use of the facilities. The LTFM also assumes that the Commissioners will retain responsibility for repairs and maintenance of the facilities. The LTFM assumes that use of premises will be cost neutral. Facilities are subject to a detailed work stream.
- Business Change 13 (Cost Pressures) – The underlying assumption in the LTFM is that the SE will manage its cost pressures and not seek additional funding from Commissioners.

5.43 It is recognised that more work needs to be done to the Integrated Business Plan to ensure the proposal is viable and that this work needs to be undertaken with GP representatives. The initial work shows that the social enterprise option will require significant additional levels savings each year to meet the PCT and Council's financial targets and the additional costs of a social enterprise, including generating a surplus to underpin its financial stability. This will need to include a discussion with the provider and commissioners about what is achievable through efficiencies and service changes.

5.44 The Financial Implications section of this report sets out the various issues and tests for the viability of a social enterprise. It should be noted that these test apply equally to other options and will also require commissioners to be clear about what is achievable within the available resources across the options.

5.45 However, it should be noted that in terms of even the baseline savings required by the PCT and the Council in future years it can not be assumed that these will all be passed to the provider under any option but that commissioners will also be required to define changes in level of services.

5.46 A process of due diligence will be carried out for the Council, NHS B&NES and the new provider to test the assumptions in the Integrated Business Case prior to any formal transfer of staff or services. Should there be any significant changes in assumptions that make the proposal unviable or unacceptable to GP Representatives, the Chief Executive will bring forward a further report to Council.

Governance and the Potential Legal Form for Social Enterprise (Appendix 5)

5.47 While this section of the report focuses on potential governance arrangements for a potential social enterprise the Council will need to take into account the differences in possible governance arrangements between the options, which can be summarised as follows:

- A social enterprise offers the opportunity for a wide range of stakeholder involvement, including the democratic input of the Council as well as GPs as future commissioners.

- The NHS option may be more restricted, in particular the input of the Council in the governance arrangements in relation to its services within the rules for NHS Trusts and Foundation Trusts. The cost of additional governance arrangements within the NHS to include Council services is difficult to assess given the lack of widespread experience of the transfer of social care services to an NHS body.
- The Council option will have to accommodate clear arrangements for clinical governance.

5.48 Given the timescales, it has been necessary to conduct a review of the options for the organisational form for a social enterprise should the Council (and the PCT Board) decide that this as the way forward.

5.49 The specific legal form of a new organisation is influenced by the objectives of that prospective organisation, which in this instance should take into account the objectives of the Council and NHS B&NES. In turn the specific legal form of the new organisation and its objectives then influences the governance structure of the social enterprise.

5.50 The analysis of the prospective legal form and governance arrangements of a new organisation should this prove viable and if the Council decides that this is the way forward is shown in Appendix 4, including the options considered. The Council has also received a background paper on the organisational options.

5.51 It would appear from the analysis that there are two potential forms of new organisation:

- A Community Interest Company underpinned by a Company Limited by Guarantee.
- A Charitable organisation again underpinned by a Company Limited by Guarantee.

5.52 Both legal forms have the following features:

- They are both forms of non-profit distributing organisations. Any surpluses may be re-invested in the organisation to improve services, provide reserves, expand the business etc.
- There is no right to returns to shareholders as neither has shareholders.
- The organisational form permits (by application for a Direction) existing staff access to the NHS pension scheme (under certain conditions) and (by application for Admitted Body Status) for Council staff although the latter will be at a potential additional cost.
- Both options (together with other options) provide an opportunity for the involvement of stakeholders in their governance, including the Council either through membership of the company or in the case of a charitable organisation through Directorship/Trustee status as well as membership.

5.53 In addition, for a Community Interest Company:

- The company is required to have a clear Community Interest Statement to reflect its community objectives.
- The company will be regulated by the Community Interest Company regulator to ensure it is meeting the stated intentions of its Community Interest Statement.
- There is an asset lock, which requires assets to be disposed of for market value. Assets are defined widely so that this includes the remuneration of Directors.

5.54 In addition, for a Charitable Organisation:

- The Charity is required to have a clear set of charitable objectives, which are generally more narrowly drawn than a Community Interest Statement although this may not necessarily restrict a new organisational form.
- There may be certain tax advantages and disadvantages, which may make a new organisational form more viable.
- The company will be regulated by the Charity Commission regulator to ensure it is meeting the stated intentions of its charitable objectives.

5.55 The detail of the organisational form will, if a social enterprise should prove viable and if the Council and the PCT decide that this is the way forward, be developed after the Council and PCT's decisions.

5.56 The governance of the two organisational forms broadly consist of:

- Membership of the Community Interest Company and a separate Board of Directors consisting of Executive and Non Executive Directors
- Membership of the charitable organisation, a Board of (unpaid) Directors/Trustees and a separate (paid) Leadership Team

5.57 Such stakeholder involvement may include the following:

- The Council
- The relevant local statutory health body
- The public/service users – possibly including, but not limited to, Local Strategic Partnership representatives
- Staff representatives
- The organisation's leadership team

5.58 There are a number of ways key stakeholders could be represented:

- As members of the company in both a Community Interest Company as well as a charitable organisation. There are certain statutory rights of members (including the removal of Directors) and others that can be added by agreement
- As unpaid appointed Directors/Trustees of the Charity should this be the

appropriate form

- As appointed paid Non Executive Directors of the Board in the case of a Community Interest Company

5.59 Some suggested broad principles to structure the non clinical governance arrangements of a social enterprise (charitable or otherwise) which balance the interests of the statutory bodies, staff, the Directors and user are as follows:

- That the statutory bodies (the Council and the relevant NHS body) could have an equal voting capacity and a combined majority of votes as members of the Community Interest Company or the Charity. It should be noted that currently PCTs only have a power to participate in companies in relation to LIFT or income generation schemes. There is no general power for such participation and Secretary of State approval would be required.
- That the Council and the relevant NHS body individually should not be able to have a majority vote as members of the CIC or charity without at least another voting constituency (e.g. directors, staff, the public/users)

5.60 The appointment of Directors/Trustees of a potential charity or the Non Executive Directors of a Community Interest Company will need to balance who can nominate such Directors and how many with the need to ensure the right mix of skills. The over-riding principle should be that the social enterprise has the right skills on the Board to ensure effective strategic leadership. There may also be specific requirements or guidance from Government as models are progressed.

5.61 The SE model can and will consider further opportunities for integration with GP Provider services as matters progress and with related amendments to governance structures.

5.62 The Council is asked to agree the broad principles of stakeholder representation should a new social enterprise be possible. The Council is also recommended to delegate the agreement of the precise legal form of the social enterprise and its governance arrangements on behalf of the Council to the Chief Executive. Similar arrangements will be recommended to the PCT Board.

Project Arrangements and Next Steps (Appendix 6)

5.63 If the Council and the PCT Board agree to a way forward the implementation will need to be managed on a project basis.

5.64 Project governance arrangements have been established and it is proposed to continue those arrangements into implementation should the Council and PCT Board agree a way forward. Those arrangements include the role of this Panel to oversee the implementation of the option agreed by the Council (and the PCT).

5.65 The project governance arrangements are shown in Appendix 6. The key features of the governance arrangements include:

- Clear Member, PCT and officer leadership
- Arrangements to minimise conflicts of interest
- The involvement of the emerging/transitional GP commissioning structure
- The inclusion of both the Council's Audit Committee and NHS B&NES Audit and Risk Committee as a key source of assurance for the Council and NHS B&NES
- A key role for the current Health and Well Being Partnership Board, which may need to be reviewed in the light of changes proposed in the NHS White Paper.
- A key role for the Healthier Communities and Older People Overview and Scrutiny Panel to oversee the implementation of any agreed option.

5.66 If the proposal is agreed by the Council and the PCT Board and approved by NHS South West and the Department of Health, there is a challenging implementation plan. The main next steps are summarised below:

- Establishing a new organisation in the proposed legal form or to transfer services to the relevant NHS Body, the Council or both
- Further detailed work on the business plan for any chosen option, including support services, estates and other financial/affordability challenges
- Developing the contractual arrangements where necessary
- Due diligence work on the part of the Council, NHS B&NES and any provider
- Finalising the business plan and contracts with the provider, including any adjustment to pooled budget arrangements
- The transfer of staff where necessary

6. RISK MANAGEMENT

6.1 Various risk assessments and risk management arrangements for the proposed changes have been put in place in compliance with the Council's and NHS B&NES risk management guidance. In many instances there are common risks which need to be managed.

6.2 The Council and NHS B&NES corporate risk registers will be revised to reflect these risks and be monitored in the usual way by management and through the Council's Audit Committee and the PCT's Audit and Assurance Committee.

6.3 In addition, due diligence from the different perspectives of the Council, NHS B&NES and any provider will be carried out throughout the implementation period and finalised prior to the transfer of services and staff.

6.4 The risks common to all options can be summarised as follows:

- Local GPs are indicating their expectation that the design of services and the organisational form should remain fluid until they have had chance to form their views on the way forward. As the prospective commissioners of NHS services and individually as the major gatekeepers determining access to services, they have the potential to affect the viability of any of the proposed options.
- Competition for health services across all the options. The indication from the Department of Health that Any Willing Provider (AWP) will apply for NHS Community Services from October 2011. This policy is intended to promote choice for service users and encourages new market entrants to compete directly for NHS business – the mandated NHS contract only includes indicative cost and volume it does not denote security of income.
- Security of income in terms of the length of contract.
- The risk that either the PCT or the Council might invoke the terms of the current Partnership Agreement and in particular require adherence to the term of notice [need to check the precise wording & include].
- Leadership capability.
- Project & business planning costs.

6.5 The risks & opportunities that vary between options include:

- Focus on integration across the options given other organisational objectives.
- Quality and improvement across the options given other organisational objectives.
- Recruitment & retention
- Taxation (VAT)
- Pension costs
- Working capital
- Costs of implementation.

Project Risk Management

6.6 A detailed project risk assessment was undertaken during this phase of the project i.e. up to this decision making point. Clearly the risks change when the project enters its implementation phase and the risk assessment and risk management arrangements will need to be adapted to the decisions of the Council and the PCT Board.

6.7 The generic key risks are:

- The challenging timescale of 1 April 2011.
- Continuing changes in national policy may change contractual arrangements, which may be a risk or an opportunity.

- The viability of any solution including resolution of estates, pensions, taxation, working capital, equal pay and contractual issues.

7. FINANCIAL IMPLICATIONS

7.1 The financial implications identified in this section apply to a varying degree to each provider option set out in the report.

7.2 The specific issues identified here relate to the recommendation and proposed delegation for continuing to develop and explore a social enterprise as the preferred option for the transfer of integrated community health and social care services. Further work needs to be undertaken to clearly identify and quanfify the related benefits and costs.

7.3 In testing the viability of the social enterprise the specific objective will be to establish an Integrated Business Plan that shows the organisation could be expected to deliver all financial requirements whilst maintaining the business as a going concern. Any potential trading deficit will need to be viewed in the context of the overall £48M business and the individual rights of all the potential creditors of the social enterprise.

7.4 The following key financial issues will be appropriately modelled within the Integrated Business Plan and will also need to be addressed within the terms of the specific delegation:

- Baseline Savings - the baseline savings identified by the Council and PCT Commissioners are £2.9M for 2011/2012 rising to over £9M by 2015/2016. These savings are potentially required of any option in terms of delivering the existing Commissioner financial plans. The Commissioners will also need to review the savings required of the provider and how these might be delivered from looking at efficiencies within the provider to agreeing new ways of working, service redesign and potential areas where service levels might be reduced. The availability of additional Government funding for these service areas via both the PCT and Council will also need to be considered. This is consistent with the PCT and Council commissioners' approach with all providers.

- VAT - the current model for the social enterprise would be unable to reclaim VAT on relevant goods and services. This represents a potential additional cost or additional savings requirement currently estimated at £1.1M.

- Contract Length – the business case will initially be modelled based upon both 3 and 5 year contract terms. This will need to be tested with GP's and EU procurement rules. The contract end arrangements also need to be clarified to establish the ongoing position of the social enterprise in the event some or all of the contracts are lost at this point.

- Financial Reserves – the social enterprise will need to establish suitable financial reserves to meet unforeseen costs and trading variations. These will need to be built up from trading activity and will present a further cost saving challenge. Based on estimated turnover reserves of approximately £2M should be targeted.

- Severance Costs – funding of severance costs (redundancy and related pensions costs) arising as a result of baseline and further savings requirements should be accounted. The Council and PCT Commissioners will need to consider appropriate funding for such costs to support the delivery of the baseline savings set out above.

- Working Capital – this requirement can be minimised by the Council waiving existing standing orders in order to allow the social enterprise to be paid monthly in advance. Maximum financial exposure for the Council is estimated at £2M.

- Governance and Other Recurring Costs – these are currently estimated at £0.5M per annum although further work is required to support this estimate. This represents a further cost saving challenge.

- Investment Costs – specific provisions for investment costs should be offset by equivalent cost savings as part of a specific business case. The social enterprise and/or commissioners will need to identify potential commercial funding to support such proposals.

- One-Off Set Up Costs – currently estimated at approximately £1M although this could be reduced by funding from a Social Enterprise Grant and any balance remaining in the approved pooled project cost budget.

- Resourcing – in the context of the overall timetable the Integrated Business Plan will need to consider the specific project resourcing requirements including the significant challenges to implement and maintain a suitable financial management, reporting and control environment for the social enterprise.

7.5 There are likely to be significant financial benefits as a result of maintaining the integration of Community Health and Social Care Services. Further work needs to be undertaken to clearly identify and quantify these costs.

7.6 In considering the specific delegation an evaluation will need to be made as to whether the Integrated Business Plan can be delivered within existing approved budgets in the context of the overall financial challenge facing the Council and the current budget planning process. This will include consideration of resource prioritisation within the Council and PCT together with the allocation of additional funding for health and social care services announced by the Government as part of the Comprehensive Spending Review.

7.7 The role of the commissioner in terms of contract and financial monitoring together with the specific allocation of responsibilities, particularly in terms of support services could impact upon the Integrated Business Plan. This work needs to be developed to ensure the overall financial implications for the Council can be identified.

7.8 The additional financial resources needed to complete the transfer of Community Health and Social Care Services are assessed as £700,000, including a contingency sum, which has been identified from existing budgets and reserves of the Council and PCT.

7.9 The Council and NHS B&NES have entered into a pooled budget arrangement for these costs which sets out:

- That joint costs are shared 50%/50% as between the Council and the PCT
- A high level communication protocol
- A high level information/advice sharing protocol with rights for both parties to seek their own advice should differences in views be irresolvable

7.10 The project costs include joint working with the current internal provider. However at the point the new organisation is set up and the Board and Leadership Team are appointed (expected February/March 2011) it will be essential that the Board and Leadership Team seek there own advice should they so wish. Alternatively, if the option to be pursued is a transfer to an NHS Trust that Trust would need to make its own provisions for the cost of preparing for the transfer.

8. LEGAL IMPLICATIONS

Powers

8.1 Local authorities have a general power to enter contracts to enable them to discharge their functions, but this needs to be distinguished from a delegation enabling a third party to exercise the unique powers of the authority. Where a local authority has a statutory function, Section 1 of the Local Government (Contracts) Act 1997 gives it the power to enter into a contract "for the purpose of or in connection with" the discharge of that function. This is a very broad ability for a local authority to buy goods and services from any appropriate source, whether that be a public body or a private sector provider, where that will assist in the discharge of the authority's functions, but needs to be distinguished from the exercise of the statutory powers which have been granted to the local authority. This is dealt with under "Delegations" below.

8.2 In terms of the proposed transaction, the Council has powers, which it is currently exercising to provide services and can enter into contracts with third parties.

8.3 Similarly under the Local Government act 1972 the Council has powers to lease property.

8.4 The PCT's relevant powers to enter into the contracts and leases are those set out in Section 9 and Schedule 3 of the National Health Service Act 2006.

8.5 In using its powers the Council (and the PCT) will need to ensure an appropriate exercise of those powers, on the particular facts. This is a matter of general public law decision-making and the Council must be satisfied that it has taken into account all relevant considerations, is not taking into account irrelevant considerations and is acting proportionately in respect of any European or Human Rights Act implications.

8.6 In this latter context it may be relevant to note that transfer to a social enterprise may for some functions mean that the provider ceases to be a public body for the purposes of the Human Rights Act 1998. Where this is the case the NHS Community services Contract and the NHS constitution require all providers under contract to meet those standards and a similar approach may be taken by the Council where this is the case.

8.7 Similarly under the social enterprise option the organisation will not be subject to Freedom of Information requirements. In the context of this proposal, the ability of the commissioners to require compliance under contract should not lead to any difficulty.

Procurement

8.8 In terms of procurement, the relevant European Union (EU) Rules are contained in the Public Contracts Regulations 2006 (as amended) and wider EU Law (The EU Rules). These rules apply where contracting authorities such as the Council and the PCT enter into contracts in writing with service providers that are above a prescribed limit in value unless any applicable exemptions apply. The EU rules divide services into either 'Part A' or 'Part B' services. Part A services are subject to all the EU Rules whereas Part B services are only subject to some of them. The services that would transfer are health and social services and these are classified as Part B services. This means they are subject to the lighter regulatory regime.

8.9 There is an element of risk that a claim could be made based on a breach of the underlying Treaty principles. Legal advice indicates that at present there seems to be little appetite for challenge of this nature to transfers of PCT provider services across the country, and the need for an integrated provider would also diminish the likelihood of a claim. Legal advice taken indicates that a claim from a would-be contractor is relatively unlikely, although there is a risk that if complaints were made to the European Commission they might want to take the matter up. The length of contract may mitigate this, by which time new commissioners move to a competitive process earlier rather than later. This would appear to increase the risk of

challenge of an interim solution to transfer services to the NHS or the Council on a temporary basis.

8.10 The EU procurement rules do require the award of a contract for Part B services to be notified and published in the OJEU using a Contract Award Notice. It is also important to ensure that any technical standards used are non-discriminatory and are EU standards (or equivalent).

Delegations

8.11 In principle the Council must retain functions that require it to act in a particular way and where it is making decisions in the exercise of functions that go beyond the day-to-day incidental decisions.

8.12 There are a number of key areas where such functions cannot be delegated and for which sufficient resources will need to be maintained if for example the option to create a social enterprise is pursued, including:

- Assessment and care provision decisions made by the Council under s47 of the NHS and Community care Act 1990 where the Council is under a statutory duty to assess and make a service provision decision where it considers that an individual may be in need of community care services. While the information gathering element of the assessment can be carried out by an external body, the approval of the assessment and the care plan (where appropriate) should be retained by the Council, and indeed reviews should be a matter of reporting back to the Council. The Council's contract with the provider would require the provider to deliver the care in accordance with the care plan, and may include a degree of latitude in terms of variations to the plan to meet marginal changes of need. Similar arrangements will be necessary in relation to Continuing Health Care and Free Nursing Care assessments for which the decision-making has to remain with the PCT under current legislative arrangements.
- Personal budgets and direct payments - the initial establishment and payment arrangements must sit with the Council (or the PCT if and when health personal budgets become relevant to the NHS).
- The function of appointing Approved Mental Health Practitioners must remain with the Council but it does not need to employ them.
- Safeguarding issues - key decisions for example: whether an alert is a safeguarding issue; whether to proceed to formal investigation; and any decisions to terminate the process would be taken by a relevant Council officer.

8.13 More detailed work is being carried out on these functions (and others, for example the deprivation of liberty) to determine the best arrangements and the resources that will need to be retained. This will include consideration to retain the budgets and functions for the Council's placement budget with other providers (so called micro-commissioning).

External Approvals

8.14 Because of the integrated nature of the services, the options have differing requirements for approval for the transfer of health services (not Council services). NHS South West has indicated that the social enterprise option would not require any further approval beyond the Strategic Health Authority and the Department of Health. This would appear to be the case for a transfer to the Council.

8.15 However, under the options to transfer to an NHS body, the approval of the NHS' Cooperation and Competition Panel would be required if services went to an NHS Trust and the approval of Monitor if the decision had been to select from NHS providers and a Foundation Trust depending on the size of the services transferred and the size of the proposed NHS provider.

Employment Issues

8.16 Employment issues are dealt with in section 9 of this report.

Partnership Issues

8.17 It should also be noted that that there is an agreement in place between the Council and the PCT that covers existing partnership arrangements. Under that agreement it would normally be appropriate for any material change in the arrangements (or any notice of termination) to be given by 12 months notice on 1 April of the relevant year. However, the Council and the PCT are making every effort to progress revised arrangements in accordance with the Coalition Government requirements and without invoking the terms of the agreement. It is important, however, to recognise that there is a formal agreement currently in place to protect all parties.

9. EMPLOYEE IMPLICATIONS

9.1 Around 1,700 staff (including relevant support staff) currently provide the in-scope services. Of these approximately 700 are currently employed by the local authority and 1,000 by the NHS. Under current partnership arrangements, members of staff retain the terms and conditions of their employer and employment policy and procedures have been harmonised wherever possible (recognising different governance arrangements in some cases).

9.2 HR consideration on each of the future options has to date been based upon an assumption that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) would apply to the transfer of the services. Any new staff recruited to the new organisation after the transfer to work alongside the staff who transferred from the local authority or the PCT will be engaged on terms and conditions of employment determined by the organisation to which they transfer. A new organisation may consider the application of the Code of Practice on Workforce Matters in determining those terms and conditions, parts of which are currently under review by the Coalition Government.

9.3 The staff group is covered by two different public sector pension schemes (the NHS Pension Scheme and the Local Government Pension Scheme

(LGPS)) for which different regulations are in place. Provisions exist within the existing LGPS Regulations, subject to the agreement of the Avon Pension Fund and the affordability of any additional pensions costs, to allow the employees transferring from the local authority to continue to have access to the LGPS. Within Health it is anticipated that Direction Employer Status would be granted to the new organisation if the Right to Request is successful. If granted, the majority of pension benefits would continue to be available to those staff who are in current membership of the scheme and who transfer from the PCT. Alternatively, the new organisation could ensure that it provided access to a broadly comparable pension scheme. Under current requirements, both the local authority and the PCT would need to satisfy themselves that the new organisation could afford appropriate pension provision before the staff transfer to the new organisation.

9.4 In the event that, as part of the new arrangements, the relevant transfer is to the Local Authority rather than a new organisation, then those employees who are currently employed by the Local Authority would remain employed by the Local Authority and therefore able to remain members of the LGPS. In relation to those NHS employees employed by the PCT, their employment would transfer under TUPE to the Local Authority. As this would be a compulsory transfer of those NHS employees, the PCT would need to liaise with the Secretary of State for Health to ask him to make a 'Transfer Order' for that transfer. The Transfer Order would usually provide for all existing terms and conditions of service for those employees to continue post the transfer of their employment to the Local Authority under TUPE and would also provide for those employees to continue to participate in the NHS Pension Scheme. The Transfer Order would have to be drawn up by the Department of Health lawyers before any such transfer happens, as this cannot be done retrospectively.

9.5 Alternatively, in the event that, as part of the new arrangements, the relevant transfer is to an existing NHS organisation rather than a new organisation, then in relation to those NHS employees currently employed by the PCT, their employment would transfer under TUPE to the NHS organisation and they would remain members of the NHS Pension Scheme as they would still be employed by an NHS employer following the transfer of their employment. For those employees who are currently employed by the Local Authority, the usual course of action would be for the NHS organisation to seek admission body status to the Avon Pension Fund so that those employees could remain members of the LGPS following the TUPE transfer of their employment to the NHS organisation. This is because the NHS Pension Scheme is not considered to be 'broadly comparable' to the LGPS and so if membership of the NHS Pension Scheme was offered, the Government Actuary's Department would be likely to attach additional conditions to its use which could have significant cost implications for the NHS organisation. Therefore, the admitted body status route to allow continued participation in the LGPS would be the better (and potentially cheaper) option in relation to those Local Authority employees who are to transfer to the NHS organisation under TUPE.

9.6 The staffing figures outlined above include a number of support functions, which currently provide services for the whole of or the majority of their time within the Provider function.. The final total for support staff and their inclusion in the staffing numbers will depend on which parts of support services transfer to the new organisation and a detailed review of the 'assignment' of staff for purposes of TUPE to the parts that are transferring.

9.7 Within both the Council and NHS there are significant financial challenges and there is an expectation that the future organisational arrangements will accommodate the implementation of QIPP (the NHS savings and service change programme) and MTSRP/SPA (Council saving programme and associated service changes). In order to accommodate such pressures and to be viable for the future the new organisation may need to carry out a degree of restructuring or reorganisation of staff just as is will be required within other Council and PCT activities.

9.8 Any subsequent changes resulting from the savings and efficiency programmes would need to be managed in accordance with employment law and involving appropriate consultation with staff.

9.9 Bringing staff from two separate employing bodies into one organisation and engaging new staff on potentially differing terms may pose a potential risk of equal pay claims after the transfer. Under TUPE, liability for any such claims will lie with the new organisation. A risk assessment of the implications and potential costs in relation to this is being undertaken together with steps to mitigate and minimise such risks in the short to medium term.

9.10 There will be a need to ensure that all processes associated with the organisational changes are fair and transparent and that issues of equality are impact assessed and addressed. Staff will have the right to opt out of the transfer if they do not wish to transfer to the new organisation. This will bring their employment to an end and they would not have the right to a redundancy payment.

10. EQUALITIES

10.1 Community Health and Social Care have carried out equality impact assessments over the majority of services provided over a period from December 2008 to the present. Equalities impact assessments will also be carried out in service changes to services resulting from the NHS and the Council's savings programmes or other changes in service.

10.2 With this approach any impact of service changes will be assessed. The Transfer of Undertakings Regulations will determine the transfer of services.

10.3 This approach has been agreed with the Council's Equalities Team and the PCT's lead on equalities.

11. CONSULTATION AND ENGAGEMENT

11.1 Extensive consultation and engagement has been carried out on developing the proposals to date: The arrangements and their outcomes are described below together with arrangements in place for the implementation phase of the change.

Staff and their Representatives

11.2 Early involvement of Trade unions from both organisations started in July soon after the publication of the Government's White Paper and has continued through the formation of a dedicated Management/union representative working group. The integrated Health and Social Care Trade Union forum is meeting towards the end of the month to consider the feedback from staff about the organisational proposals and the Trade Unions have been invited to submit their own views to the decision-making bodies.

11.3 A series of twelve staff engagement workshops at various locations and times have been arranged in order to get as wide an involvement of staff directly affected as possible. 524 staff (388 PCT/136 Council staff) have attended these events. The workshops have been supported by 'bespoke' materials and a dedicated website where staff have been able to access additional information and the set of frequently asked questions arising from the content of the workshops. In addition to the workshops, a specialist on Social Enterprises was invited down so that staff could gain independent, specialist information on the organisational form they were least familiar with.

11.4 As a result of these workshops 247 questions were submitted by staff, which have been responded to by management. There were also 52 individual submissions from staff resulting from the engagement events. The intranet site also received 660 visits.

11.5 It is important to note that the primary concern surrounding this issue remains the ability to best meet the needs of those using services; the interests of staff who provide those services in a dedicated and committed way needs to be balanced against the needs of those using services.

11.6 The key issues emerging from staff engagement and engagement include:

- Concerns about pensions and terms and conditions. This issue is explained in the body of this report.

- Understandably mixed views about the way forward. There are clearly expressed views that staff feel that they should remain with their current employer although there were some views expressed more positively about other options. It should be noted that the national agenda for change expressed in the White Paper indicates a significant shift in the landscape for NHS commissioning and provision. The Council is also considering the shape of its future commissioning and provision activity in response to the difficult financial climate. The provision of services will therefore change significantly over the next 3-4 years with NHS

Foundation Trusts being subject to more competitive market pressure to an extent that the future may encompass an NHS funded service but not necessarily an NHS provided service.

- The viability and sustainability of any option. This is recognised throughout the report and it is suggested further work be carried out particularly on the social enterprise option.

- There is no strong appetite to work for a profit-making organisation, although there is recognition that under any option costs have to be covered.

- Concern about working with new GP Commissioners on a wider range of services. Further reports will be brought to the Council and the PCT on future commissioning arrangements. This report recognises the key role of the newly established GP representatives in the forward development of the service delivery model and consequent organisational form.

11.7 There are further obligations under TUPE to inform and consult staff representatives of the affected employees, which will be met throughout the process.

General Practitioners

11.8 Engagement with the General Practitioner community is critical in such a proposed transfer of services in an uncertain climate for service provision. The statutory requirements, which influence the way in which PCTs seek views from GPs, are in a period of change. PCTs were originally constituted with a Professional Executive Committee (PEC), which provides clinical advice and representation to the PCT Board. Within NHS B&NES the PEC is chaired by a retired local GP, and also includes two other GP members as well as other clinicians from community and secondary care services. PCTs have also been required to have in place a Directed Enhanced Service (ie a contract) to support Practice Based Commissioning. Within B&NES this has until very recently been a B&NES wide commissioning consortia chaired by one of the GPs who also sits on the PEC, and comprising local GPs as well as other primary care staff.

11.9 The NHS White Paper published in July 2010 signals the end of PCTs as commissioners of healthcare, and the establishment of new statutory bodies of local GPs commissioning a range of services, including most community based services. It is recognised that consultation with GPs needs to take into account their transition into the primary commissioners of health services of the future while balancing this with the need to preserve stability in service provision at a local level, to promote integration of services for the benefit of patients and taxpayers and to meet Department of Health requirements for the divestment of PCT community health services.

11.10 On July 29th 2010 Sir David Nicholson the Chief Executive of the NHS wrote to all NHS bodies and to councils confirming the new tests to which

all future service reconfigurations should be subject. Proposals for change, which will include proposals developed under Transforming Community Services (TCS), need to be able to demonstrate support from GP Commissioners in order to be approved by the SHA and the Department of Health. GP commissioners are asked by the CEO of the NHS in this letter to lead local service reconfigurations and to assure themselves that the proposals meet the reconfiguration tests.

11.11 The original commissioning intentions for community services, which were produced in July 2009, were approved by the Professional Executive Committee of the PCT, the legitimate mechanism for securing GP views at the time. The commissioning intentions were summarised for the different stakeholder groups. A specific briefing on the impact on primary and community services was distributed to local GP practices and the offer of separate meetings was made to all providers, including primary care providers. In addition to the series of public meetings explaining the commissioning intentions, a provider seminar was held in September 2009 for all providers, including those in primary care. GP representation at these events was very limited. A presentation on the commissioning intentions was also made to the Practice Based Commissioning Consortium.

11.12 The initial option appraisal undertaken in February/March 2010 was presented to a seminar comprising clinical members of the PEC & PbC Consortium, PCT Board members and Council officers and members.

11.13 The Commissioner Case for Change was discussed with and approved by the Professional Executive Committee (including the GP representatives) in August 2010.

11.14 Correspondence was sent to the former Chair of the GP Forum in mid August requesting early consideration of the Transforming Commissioning Services agenda once the GPs had determined how they wished to organise themselves locally. The Acting Chief Executive of the PCT undertook individual practice visits with most but not all of the 28 practices and highlighted the need for engagement in the agenda. Practice Managers have been working with the current joint provider of services to inform the service specification as part of the business planning for TCS.

11.15 It is recognised that GPs are only just beginning to organise themselves into a forum where the future of integrated community health and social care services can be discussed. GPs within B&NES have moved swiftly to establish a group in mid September, which is designing the new commissioning arrangements. This group received verbal briefing from the Managing Director of the current joint provider in early October, and their first debate with the wider GP community took place at the end of October.

11.16 The Chair of the Overview & Scrutiny Panel invited GP Commissioner representation at the public meeting to scrutinise the TCS proposals which took place on October 28th, however this offer was not taken up and no GP view was represented at this meeting.

11.17 The speed with which the TCS agenda is necessarily being pursued in order to fit within the DH timescale and the fact that the existing statutory arrangements for ensuring a GP view at the PCT Board are being superseded by the new GP led commissioning consortia has left GPs feeling that they should have had a greater say in the development of the options and their assessment than has been the case. The emergent GP Consortia has formally requested that the decision on future arrangements be deferred until they have had more time to consider. The Department of Health has been copied into this request.

11.18 Engagement with the General Practitioner community is critical in such a proposed transfer of services in an uncertain climate for service provision. At the present time, the PCT remains responsible for the commissioning of NHS services. However, any arrangements for the future of community health services and, in addition, the integration of health and social care will require the support of future GP Commissioners if they are to remain workable and viable under any of the options.

11.19 It is recognised that consultation with GPs needs to take into account their transition into the primary commissioners of health services of the future while balancing this with the need to preserve stability in service provision at a local level, promote integration of services for the benefit of patients and taxpayers, provide clarity for all relevant staff for the future, and meet Department of Health requirements for the divestment of community health services.

11.20 Following the establishment of the interim GP Consortium Board, discussions have been held on the future provision of services. In a letter dated 3 November from the Chair of the GP representatives to the Acting Chief Executive of NHS B&NES the following points were expressed:

- A recognition of the timescales imposed by the Coalition Government with respect to the transfer of community health services, which has not allowed sufficient involvement of GPs given the White Paper's transfer of responsibilities for commissioning of health services from the PCT to GP Commissioning Consortia.

- A concern that if plans proceed without further engagement of the emerging GP Commissioners the arrangements may not be supported and therefore this may undermine future service delivery.

- A commitment to work with partners to develop joined up solutions to benefit patients and service users that are productive and cost effective.

11.21 Both the Council and the PCT are committed to further engagement with the GP community in order to ensure service stability and the realisation of long-term benefits from the integration of services.

11.22 The report suggests that if the Council and the PCT Board approve the further work on the development of a potential social enterprise this work should be developed in partnership with GP Commissioning representatives

to ensure the best possible services for the residents of Bath and North East Somerset.

11.23 Given the stage of development of the Integrated Business Case, this involvement in service design, governance and organisational form presents an important and critical opportunity. However, the Council, the PCT and GP commissioners should be mindful of the increased risk that the Secretary of State may impose a solution. The existing agreement in place between the Council and the PCT, the specific requirements of the letter from Sir David Nicholson, and the Coalition Government's statements about Integration and Social Enterprise are also germane.

Other Stakeholders

11.24 In addition to the staff engagement, phase one of the consultation includes:

- Documentation on the organisational options being circulated in a targeted but wide way and comments have been invited. This includes parish councils, (Local Involvement Network) LINks, the third sector and other providers
- The document is also available on the websites of the Council and the PCT and allows for the public to comment and express their views
- The issue has been incorporated in the latest "healthy conversations" public meetings

11.25 The Partnership Board, PCT Board and Council will also be considering this in public.

11.26 A public meeting addressing two strategic change agendas and including Transforming Community Services was held on October 15th in liaison with Bath and North East Somerset Local Involvement Network (Link). Some 40 people attended including users of services, carers, voluntary sector representatives, Disabled people, Link members and other interested parties.

11.27 The programme for change was presented and workshop style conversations specifically on Transforming Community Services were held during the morning with three participant groups.

11.28 Feedback from these sessions was mixed. People expressed enthusiasm, concerns and information requests with a variety of comments recorded. These included:

- "Undertaking minimal change is the best approach"
- "What is needed on the ground should be what drives decisions"
- "Will there be scope for third sector expansion in social enterprise model"
- "Any change should deliver more localised services"

- "Everyone needs to support change for it to work"
- "Change should cut down on bureaucracy"
- "Don't forget children's services and how they might be affected"

11.29 The varied content from the three sessions was collated and five common themes emerged these were presented back to the participants as a summary. These five themes can be regarded as the key points from the public meeting:

- Maintaining integration was valued as important by all contributors. There was a consistent request not to undermine or dismantle the partnership through any reform.
- The model chosen must be able to deliver the best service now and into the future.
- In any change process and into the future it's crucially important to ensure quality and monitor that quality to make sure standards are maintained.
- It is for the service managers and planners to decide on the organisational model. People are concerned with the delivery of the services and not the model.
- Giving good Information to people is essential, Its Important to inform people about where to get help and give people the service information they need to access the right services. Especially in a time of change.

11.30 The Healthier Communities and Older People Overview and Scrutiny Panel considered a report on the options for the future provision of integrated community health and social care services at its meeting on 28th October 2010. An extract of the relevant item from the draft minutes of the meeting are attached at Appendix 7.

11.31 The main points made at the Healthier Communities and Older People Overview and Scrutiny Panel which the Council and PCT need to consider are:

- The Panel expressed its concerns about the speed of the decision-making timescale compared to the significance of the decision. This issue is shared by the PCT and officers of both the PCT and the Council. The Council and the PCT (and GP Commissioning representatives) will need to make a judgement about the balance between the risk of the proposed way forward with the benefits of integration and the proposed solution.
- The Panel did not dismiss any of the shortlisted options presented in their report and did not add any further options.

- The Panel supported the principles of stakeholder involvement in the governance arrangements of a social enterprise should this be the option decided upon by the Council.
- The Panel noted the project governance arrangements for the implementation of the proposed option and welcomed its involvement in overseeing the implementation, subject to the introduction of the new statutory Partnership Board proposed under the NHS White Paper.

11.32 The meeting of the Healthier Communities and Older People Overview and Scrutiny Panel also received written comments from two members of the public and Bath and North East Somerset Local Involvement Network (LINks), which have been listed as background papers, as well as a verbal contribution on behalf of the trade unions.

11.33 The public contributions and officer comments (in italics) include, in summary:

- A request to consider the range of co-operative models for any new organisation if this option is pursued. *While the model is appropriate in certain circumstances, the co-operative business model is based on open membership and one-person one-vote. The principles for the governance of a new social enterprise outlined in this report sets out a number of stakeholders potential involvement and possibly differential voting rights as members of the company which would not be achievable under the Co-operative Society model.*
- A request for the inclusion of a dedicated Health Improvement Officer for BME communities within the plans for Transforming Community Services. *This is an issue for the further development of the proposals either as part of developing commissioning intentions under the new GP Commissioner arrangements or the Community Interest Statement for a new social enterprise should this model be taken forward.*

11.34 The written contribution of LINks and officer comments (in italics) included the following points:

- A concern about the timescales to provide a contribution and that this may also preclude certain options, as they are not achievable in the Coalition Government's timescales.
- Support for integration both of commissioning and the provision of seamless services.
- A recognition that a difficulty at present is the PCT's current responsibilities for commissioning the services and the involvement of the emerging future GP commissioners in developing the arrangements for which they would have to take responsibility in future. *This is recognised in this report. Now that there is a group of GP Commissioning representatives elected by the GP community to take forward the Interim GP Consortium, a mechanism is in place to*

take forward future proposals is in place. This has been established quickly after the publication of the Coalition White Paper in late July 2010. However, this report also recognises the tension between the Coalition Government timescale for the transfer of community health services and the involvement of the GP Commissioning representatives.

- Questions about the options – including the re-emergence of some options (integration with NHS Trusts) and the exclusion of an option (integration with GP Services). *The reappraisal of the options was made necessary by the proposals in the Coalition White Paper which has radically changed the commissioning environment as well as keeping to the original timescale for the divestment of PCT provided community health services. The report explains why some options, including integration with GP services (GPs are considered by the NHS as independent contractors), are not achievable, as they require tendering exercise beyond the April 2011 timescale. The social enterprise model is a managed transfer of services and could therefore still be included in the options, given the concession to make substantial progress on such options by April 2011. The reappraisal was also moderated by external advisers to ensure objectivity*.
- The risk of rejection of the all options by stakeholders through the process, in particular the social enterprise option. *None of the options is risk free and all of the options will require a deepening of the engagement throughout the process to ensure solutions meet the needs of the residents of Bath and North East Somerset, including how workable the social enterprise model will be.*
- A concern that the right to request for NHS staff was not submitted in time for the social enterprise option to be excluded. *The right to request application was made on time, as a preventative measure should the social enterprise model be chosen as the way forward.*
- An assurance that there will be further and full consultation with stakeholders on any option proposed for adoption. *At this stage the report recommends the Council continue to work in partnership with the PCT and GP representatives on the development of the social enterprise option and this will include ongoing consultation with stakeholders.*

Strategic Health Authority (NHS South West)

11.35 NHS Bath and North East Somerset have liaised closely with NHS South West throughout.

11.36 NHS South West's role is to ensure, in relation to local NHS services not Council services, that sufficient progress is being made by NHS B&NES against the mandatory deadline to transfer or to have made substantial progress to transfer its directly provided service by 1 April 2011.

11.37 NHS South West has also evaluated the project work plan; the Commissioning Case for Change (which has been recommended for approval to the Department of Health); the Contracting Intentions; and will evaluate the providers Integrated Business Plan.

11.38 It is recognised that the Integrated Business Plan for a social enterprise needs further work to establish whether a social enterprise model is viable and sustainable. This will need extensive involvement of the GP representatives and further consultation and stakeholder involvement. Due to the timescales involved discussions will be held with the SHA about the further development of the Integrated Business Case in terms of the service model and the financial challenges.

Ongoing Consultation and Engagement

11.39 Stage 2 plans for consultation and engagement are to involve service users and other groups in the shape of the services to be provided, how to performance manage the arrangements and the sorts of outcomes people would be expecting.

11.40 The report, and indeed the comments from other stakeholders, recognise the key involvement of relevant GP Commissioning representatives for the emerging GP Commissioning Consortium as partners in developing the proposals further. This is in addition to further development of the governance arrangements for any potential social enterprise to include GPs/the new statutory body subject to new legislation concerning such involvement and any potential conflicts of interest.

12. ISSUES TO CONSIDER IN REACHING THE DECISION

12.1 The issues to consider are included in the report at Section 2 of this report.

13. ADVICE SOUGHT

13.1 Advice was sought, and is reflected in the report, from:

- The Council's Monitoring Officer (Council Solicitor).
- The Council's s151 Officer (Divisional Director – Finance).
- The PCT's Acting Director of Finance.

13.2 Advice was sought from external legal and financial advisers due to the novel, innovative and complex nature of the transaction and is reflected in the report.

Contact person
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Richard Szadziewski, Project Director, Tel: 07811 462 559

Background papers

NHS Operating Framework 2010-11, (Department of Health, July 2010).

Revised NHS Operating Framework 2010-11 (Department of Health, July 2010).

Equity and Excellence: Liberating the NHS, Department of Health, July 2010.

Original Options Appraisal, March 2010.

Guidance on the Approval Process for Transactions in NHS South West, NHS South West, July 2010.

Transforming Community Services Work Plan submitted to NHS South West, July 2010.

Commissioners Case for Change, August 2010 with a revised version in September 2010.

Transforming Community Services Contracting Intentions, September 2010.

Transforming Community Services Across Bath and North East Somerset – What's Your View? Employee Consultation Document, September 2010.

Transforming Community Services Update, NHS B&NES Board, 14th October 2010.

Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated social care, Turning Point, February 2010.

NHS Mutual: Engaging Staff and Aligning Incentives to Achieve Higher Levels of Performance, Nuffield Trust, July 2009.

NHS Standard Contract For Community Services 2010-11, Department of Health (revised annually).

Background note on the various forms of social enterprise, Bevan Brittan, October 2010.

Report to and draft Minutes of Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010, including the contributions of external participants in the meeting.

LINk's Comments for Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010.

Co-operative Business Models Comments from Peter Sas Co-operative Party South West Regional Council contribution to Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010.

Needs of Hard to Reach BME Communities, contribution of Anne Marie Jovcic-Sas to Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010.

Analysis of Written Questions Submitted at Staff Meetings, September – October 2010.

Collation of Staff Feedback Forms, October 2010.

Minutes of the TCS Working Group (which includes Trade Unions), various September

Background papers
– October 2010. Minutes of the Joint Partnership Consultative Committee, various August – October 2010. Joint Management/Trade Union Meeting - Notes of meeting 21st July 2010 Letter from Dr Ian Orpen (Chairman of the Interim Bath and North East Somerset GP Consortium) to the Acting Chief Executive of NHS Bath and North East Somerset, 3 November 2010.
Please contact the report author if you need to access this report in an alternative format

APPENDIX 1

Summary of the White Paper: Equity & Excellence: Liberating the NHS (published July 12th 2010)

NHS Core Values reaffirmed: available to all; free at the point of use; based on need not ability to pay

Patient Focus

- Consumer ratings for hospitals & clinicians according to quality of care (Safety, effectiveness & experience)
- Extended range of choice: of provider, consultant led team, GP practice and diagnostic tests
- New consumer champion: HealthWatch to be commissioned by Local Authorities to replace Local Involvement Networks (LINks)
- "Information revolution" to support (based on use of information not IT infrastructure)

Focus on clinical outcomes

- New outcome frameworks for health, public health & social care
- New role for NICE to provide library of standards for health, public health & social care
- Removing existing targets that have no clinical justification
- Establish Public Health Service (White paper later in year) & responsibility for Public Health moves to Local Authorities

Empowering health professionals

- GP commissioning consortia as new statutory bodies allocated commissioning resource & required to commission with Local Authorities
- From 2012 Independent NHS Commissioning Board allocating & accounting for NHS resources.
- ALL NHS trusts to be Foundation Trusts; expansion of Any Willing Provider, expansion of Social Enterprise
- New statutory arrangements within Local Authorities [Health & Well Being Boards] to take strategic approach, promote integration across health & social care & wider council
- Health Overview and Scrutiny replaced by Council new statutory functions
- Strategic Health Authorities cease in 2012
- Primary Care Trusts cease in 2013

APPENDIX 2

Services Currently Provided by B&NES Community Health and Social Care Services

Service	*Council or Health Funded*
LEARNING DISABILITIES	
Adult Family Link Service	*Council*
Care Management & Social Work	*Council*
Community Learning Difficulties (Health)	*Council*
Day Services - Carrswood, Connections & Community Day	*Council*
Employment Development	*Council*
Maple Grove Residential Service	*Council*
Supported Living Service	*Council*
Epilepsy Nursing	*Health*
Learning Disabilities Management	*Council*
COMMUNITY TEAMS	
Access Team (Social Work Duty Service)	*Council*
Brokerage Service	*Council*
Community Health & Access Team	*Health*
Community Nurses for Older People	*Health*
District Nursing	*Health*
Hospital Social Work Team	*Council*
Intake, Assessment & Re-enablement	*Council*
Intermediate Care Service	*Council*
Intermediate Care Teams	*Health*
Locality Team - Social Care	*Council*
Occupational Therapy Services	*Council*
OUT-PATIENT SERVICES	
Adult Outpatient Speech & Language Therapy	*Health*
Contraception and Sexual Health	*Health*
Clara Cross Rehabilitation Unit	*Health*
Hearing Therapy	*Health*
OP Physiotherapy & GP practice-based clinical specialist Physiotherapy	*Health*

Service	*Council or Health Funded*
Orthopaedic Interface Service	*Health*
Paulton Hospital Minor Injuries Unit and Out Patient Department	*Health*
Podiatry	*Health*
CHILDREN	
Audiology	*Health*
Community Paediatrics	*Health*
Designated Doctor	*Health*
Health Visitors	*Health*
LD Service	*Health*
Lifetime Service (includes core & homecare)	*Health*
Named Nurse	*Health*
Population Services	*Health*
Speech & Language Therapy (includes adults and children)	*Health*
School Nurses	*Health*
Child Health (includes audiology, community paediatrics, designated doctor & population services)	*Health*
COMMUNITY HOSPITALS & COMMUNITY RESOURCE CENTRES	
Community Hospital In-Patient Services (St Martin's Hospital + Paulton Hospital)	*Health*
Community Resource Centres & Extra Care (Two of the Community Resource Centres (Midsomer Norton and Keynsham) contain 30 residential care beds, 30 extra care flats and a day centre. The remaining CRC in Bath has 45 residential care beds and a day centre with extra care provided separately alongside "ordinary" sheltered housing at St Johns Court)	*Council*
MENTAL HEALTH	
Approved Mental Health Professional Service	*Council*
Community Development Service for Black & Minority Ethnic Communities	*Council*
Community Options Team	*Council*
Home Support Team	*Council*
Professional Lead for Social Work	*Council*
Psychological Therapies	*Health*

Service	*Council or Health Funded*
Work Development Team	*Council*
Community Rehab	*Council*
SPECIALIST COMMUNITY SERVICES	
Community Alarm Service and Community Equipment Service	*Council*
Community Learning Service	*Council*
Community Lymphoedema Service	*Health*
Community Toe Nail Cutting Service	*Health*
Continuing Health Care Team	*Health*
IMPACT Service	*Health*
Hearing and Vision (Sensory Impairment) Team	*Council*
Specialist Community Neuro-Rehabilitation & Stroke Service	*Health*
Specialist Community Nursing Services	*Health*
Heart Failure Nursing	*Health*
Diabetes Education	*Health*
Care Home Support Service (In reach nursing)	*Health*
Tissue Viability Service	*Health*
Continence	*Health*
HEALTH IMPROVEMENT SERVICES	
Food in Schools	*Health*
Food Worker Programme	*Health*
Health Improvement Service	*Health*
Health Trainers	*Health*
Stop Smoking	*Health*

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Transforming Community Health and Social Care Services

Next Steps in Working Together – Options Re-Appraisal

Updated October 2010

Introduction

Over recent years there has been a shared vision across governments to put people first through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity.

Previous Governments and the present Coalition Government have highlighted that a vital pre-requisite for success was that key bodies in health, social care and housing work together to ensure shared practices that offer potential for better service outcomes, greater efficiency and improved service user satisfaction.

In December 2009 the Department of Health published both its five year plan *"NHS 2010 – 2015: from good to great"* and its Operating Framework for 2010/11. The Plan was developed to set the direction for the reshaping of the NHS to meet the challenge of delivering high quality health care for all in what we know will be a tough financial environment. Its key message is the need for the NHS to organise care and services around patients with a new drive towards more preventative and more productive services.

The Coalition Government's Revised NHS Operating Framework 2010-11 (June 2010) reaffirmed this policy direction and the NHS White Paper (July 2010) subsequently introduced the intent to dissolve PCTs by 2013 and therefore to proceed with the provider divestment programme, even if this meant transfer to other organisations while a medium to long term solution is developed.

The revised operating framework stated that, "proposals should be capable of being implemented, or substantial progress made towards implementation, by April 2011."

Working across boundaries is something familiar to Bath & North East Somerset. The Health and Well Being Partnership is working hard to bring about closer working between health and social care services and the development of community teams in local areas is aimed at making this happen in partnership with primary care colleagues and services. A number of joint initiatives between our community and acute hospital providers to reduce unnecessary hospital admissions or unnecessary long stays in hospitals are also helping to ensure that boundaries between different providers do not fragment care.

The next three years are pivotal. The public sector, in keeping with the rest of the community, is facing significant financial challenges and this, linked to the year on year improvements that all services need to sustain, means that the public sector will need to "tighten its belt" which will need radical approaches and innovation in order to transform services, improving the quality of services while also reducing costs.

Bath & North East Somerset has set out its service transformation agenda in *"Transforming Community Health and Social Care in Bath & North East Somerset – 2010/11 – 2014/15".* Although this is focussed on service change it recognises

the need for the development of a new and dynamic organisation to provide community health and social care services.

In March 2010, a document was prepared that outlined the first step in setting out the case for change; the options around future organisational structures and the proposed next steps to achieve our aims.

Since March, there has been a change of Government and this has led to new and/or updated policies including a Revised Operating Framework for the NHS (June 2010) and the publication of a White Paper "Equity and Excellence : Liberating the NHS (July 2010).

Of particular relevance in both these documents has been the requirement for the NHS to ensure that the PCTs divest themselves of their provider services by April 2011 or to make substantial progress towards this. The Revised NHS Operating Framework states:

"Separating primary care trust commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring to other organisations whilst sustainable medium term arrangements are identified and secured. PCTs should therefore continue to develop and review proposals for the divestment of their directly provided community services.

As a result the PCT together with its Local Authority partner has considered again the range of options available for the future provision of services.

This document is an updated version of the March options appraisal taking account of the further developments since the General Election in May 2010.

This document sets out the context in which community services have developed in recent years across Bath & North East Somerset and the options still under consideration for the potential re-shaping of the organisational form of these services. Although there are nationally imposed imperatives in taking this forward for the NHS our local proposals support the direction of travel already begun in B&NES and the partnership that exists between NHS B&NES and the Council. Effective engagement and joint decision making remains essential, despite the challenging pace, and there continues to be full and meaningful discussions on the proposals to assist both the PCT and the Council in its decision making processes.

Section 1 - Background and Context

Local Context

The key drivers for the provision and development of services locally are set out in the document *Transforming Community Health and Social Care in Bath and North East Somerset – Commissioning Intentions 2010/11 – 2014/15, the Commissioners Case for Change (August 2010*) and conditional *Commissioning Intentions (September 2010).*

An overriding and consistent theme is that of quality as the organising principle that will enable the provision of safe, effective and personalised care. The challenge for providers will be to demonstrate their role in the transformation of services that improves quality, reduces inequalities and ensures value for money through increased productivity and innovation.

In this context, the PCT and the Council are working together on a change programme that is already pursuing a route of separate commissioning and delivery functions. Against this background, "Community Health and Social Care Services" (CHSCS) was established in 2009 as a separate provider within the Partnership delivering seamless care across both health and social services. To date, significant benefits around improved service user experience; less duplication of provision and sharing of skills and learning across different workforce groups are being reported and the partnership wishes to continue to build on these successes.

Although services are now working together within a single management structure, formal accountability for services still remains separate within the PCT and the Council. This creates complexity in governance and, for example, results in staff needing to follow separate policies and having different terms and conditions of service. This is not the optimal or most efficient way of running front line services.

The next step, therefore, is to look at a range of options for a new organisation that will support the continued bringing together of services and the delivery of the key strategic objectives of the Partnership, especially in relation to the personalisation agenda.

Whatever organisational form is agreed must be able to demonstrate added value for local people and for those using our services. In other words any future form must be able to demonstrate:

- Improved quality of care: better experience for the service user, safer services, and the agility to respond quickly to latest best practice in health and social care.
- Ongoing sustainability of integrated provision and the benefits that this delivers for service users
- Robust governance arrangements to ensure patient and service user safety, effective performance and the safeguarding of significant public funds.
- Improved value for money for commissioners of health and social care.
- Cash releasing savings in line with already agreed plans (The Council's Medium Term Financial plan & the NHS QIPP programme).
- Ongoing financial viability

Section 2: Options for Future Organisational Forms

Overview

The continued close working of health and social care services is important to the Health and Well Being Partnership and is a direction of travel that the Partnership wishes to continue and strengthen. There is increasing evidence that the bringing together of service delivery around the needs of the individual can improve outcomes through:

- Avoiding duplication of service provision by different professionals and/or in different settings
- Reducing inefficiencies in care
- Reducing opportunities for individuals to "slip through the net" between health and social care and within the different tiers of healthcare delivery
- The development of common standards and sharing of best practice

In this context any options for organisational form will need to demonstrate how the ongoing joint working can continue to be achieved and strengthened.

The Commissioning Intentions of the Health and Well Being Partnership has set out a number of assumptions and requirements that will need to influence and shape any future proposals for organisational change including:

- An expectation that all providers will contribute to a system wide culture of self care and self directed care in order to promote independence, choice and control. This will include:
    - Providing people with comprehensive information and support to navigate the system
    - Rolling out personalised budgets and the associated support mechanisms
    - Delivery in primary, community and secondary care of brief interventions that signpost people to support services for lifestyle change.

- A need for primary, community and secondary care services to work closely together to prevent unnecessary hospital admissions, provide locally sensitive and accessible services and support the prevention and well being agenda.

- A shift of resource from specialist interventional services into early intervention and prevention, including advocacy information and advice to create a sustainable system of health and social care for the future.

- A requirement for all providers to cooperate in identifying and implementing changes that deliver net reduction in spend across the system as well as

improving their own internal productivity in order to cope with the anticipated financial and demographic challenges ahead.

- Innovation to bring about change in these financially constrained circumstances. Examples could include the use of technology to support people in the community in order to reduce lengths of stay or to encourage independence and avoid the need for admission either to hospital or to long term care.

- A commitment to working with all partners in the public, commercial and voluntary sectors to create the kind of environment which enables people to live a healthy lifestyle.

This highlights the enormity of the challenges ahead. It is not only the significant financial challenges that services need to respond to but also an emphasis on quality, safety and individual experiences of services.

B&NES Community Health and Social Care Services (CHSCS)

B&NES Community Health and Social Care Services is the current provider of services established as part of the B&NES Health and Well Being Partnership. The Managing Director for CHSCS holds formal accountability to both the Council and NHS B&NES for the services managed and there are joint management arrangements in place across all service areas.

Current services are provided through joint Community Adult Health and Social Care Locality Teams, supported by a range of specialist services in two Community Hospitals, three Community Resource Centres and a range of other centres and clinics across the area. Community Health & Social Care Services (CHSCSS) also provides children's healthcare services commissioned from and working in close partnership with the Children and Young Families Directorate of the Council.

The three community health and social care teams, which work in the defined geographical areas of Bath, Keynsham & Chew Valley and Norton/Radstock & Paulton, have been in place since April 2009. It is anticipated that these will develop over time, but the first phase has seen the integration of the following services:

- Social work and care management staff
- Social care Occupational Therapy services
- District nursing
- Community matrons
- Intermediate care services including rapid response, facilitation of discharge, community rehabilitation teams and in-take & re-enablement service
- In-reach nursing service
- Administration staff associated with the above services

The model of care is driven by a single assessment for health and social care needs and a multi-professional team developing with service users personalised packages of health and social care that meet their needs. The locality teams provide advice and information, assess and respond to immediate care requirements and arrange individual care packages as required.

These three localities are supported by the Community & Health Access Team which offers the first point of contact to health and social care professionals and the public wishing to contact care professionals and is co-located in one of the Council's facilities. Clinical staff within the Access Team provide support and advice to general practitioners and health professionals regarding potential hospital admissions and support the discharge process by coordinating health and social care services to assist timely discharge.

The CHSCS service currently includes the provider elements of the public health service, in particular the health promotion service, health trainers and the specialist smoking cessation services. Responsibility for health improvement and tackling health inequalities is expected to move to the Local Authority as indicated in the recent NHS White Paper. A further White Paper on public health is expected later in 2010 and there is currently a Select Committee enquiry gathering evidence on the future shape of public health services. For planning purposes it is currently assumed that the health promotion service would remain within the provider services, however this may be subject to change if this is inconsistent with future public policy.

A number of healthcare services are provided by B&NES CHSCS on a wider geographic basis. Income for these services is secured through contracts between CHSCS and the relevant PCTs. Most notably:

- Consultant Community Paediatrics and Child Health Administration services are provided to two other PCT areas (parts of Wiltshire and Somerset)
- Specialist Services for supporting seriously ill children at home are provided to five other PCT areas (parts of Wiltshire and Somerset; Bristol, North Somerset and South Gloucestershire)

The current gross budget for CHSCSS is over £80m. This is made up of £56m for directly provided services and £26m which is used to sub contract services from the independent sector most significantly residential and nursing home placements.

In addition to the direct service provision identified above, as an arms length body sitting with statutory organisations, it has to date been possible to devolve to the CHSCS a number of statutory functions of both the PCT and the Council:

- CHSCS staff currently agree people's social care needs assessments and reviews and agree support plans to meet these needs. CHSCS staff similarly assess people's needs for continuing health care and often influence how

these needs are met. The budget for meeting these needs currently sits with the commissioner rather the provider.

- With the exception of one senior member of staff leading on Safeguarding Vulnerable Adults, the body of social work expertise currently sits within the CHSCS and there is an internal service level agreement for CHSCS to undertake safeguarding investigations on behalf of the commissioners.

In order for the commissioners to meet their ongoing statutory duties, and for the financial risks to which both commissioners and provider are exposed to be manageable, accountability, decision making and risk need to sit in the same organisation in order to ensure appropriate control and stewardship of resources. For this reason further discussions are ongoing around the range and levels of purchasing services that will remain within the commissioning function, most notably in relation to the purchasing of residential and nursing home care. In addition to the funding itself, there is a need to approve assessments of need undertaken by the provider, and the packages of care put in place to meet these. The model of how this would work is currently being finalised through a more thorough assessment between the commissioners and the current provider.

For similar reasons discussions are also ongoing around the accountability for setting the strategic direction for safeguarding, including coordinating the multi-agency Safeguarding Adult interagency Partnership Board and leading the investigation of safeguarding alerts.

Consideration was given by the clinicians on the Professional Executive Committee (PEC) to the inclusion of Medicines Management within the provider services being considered. However this is not part of the current proposal. If we follow the logic that risk, accountability and decision making need to sit together, then it is important that Medicines Management transfers from the current PCT to the new GP Commissioning Consortia.

At this stage it is assumed that NHS assets would not transfer to any new provider body but that facilities would be leased back by whichever successor body to the PCT is the recipient of these assets. Community Hospitals continue to play an integral part in the future vision of an integrated health and social care service although the range and style of services provided on these sites may change in time.

Similarly it is assumed that the Council assets associated with the provision of community social care, including the Community Resource Centres, would remain within the Council, but would initially be available for lease back by the new provider organisation. The strategic intent of the Partnership remains unchanged: the opportunity provided by the Community Resource Centres is not yet being fully realised as part of the integrated provision and, as with the Community Hospital sites, the Community Resource Centres offer real potential to develop a very different model of care. The commissioners would want to ensure that this potential is fully utilised to provide the best outcomes and the optimal value to tax payers. It should be stressed, however, that the Council has yet to take a formal decision with regard to the use of its assets.

Consideration of Options – March 2010

In March an initial appraisal of the range of options available for the future provision of the current health and social care services was undertaken.

The full range of options considered was:

Option 1: Remain as is
Option 2: Standalone community provider services : Community Foundation Trust
Option 3: Standalone community provider services : Social Enterprise
Option 4: Operate as “arms-length” within local authority
Option 5: Integration with Royal United Hospital NHS Trust
Option 6: Integration with neighbouring PCT provider services
Option 7: Managed dispersal of services
Option 8: Integration with GP Services
Option 9: Integration with Mental Health Trust
Option 10: Integration with Charity/Third Sector
Option 11: Private Sector

A high level assessment of each of these options was undertaken through a number of seminars with key stakeholders.

As a result of the assessment, a short list of option for more detailed consideration was drawn up.

The key overriding principles against which a short list was developed were:

- The need to continue and strengthen the integration of services
- A focus on the local population
- An organisational structure that can provide strong leadership, governance and culture and add value to the local partnership
- Increased quality, innovation, productivity and efficiency
- Equal focus on health and social care services
- Staff stability and sustainability of organisation
- Continuity of Service Delivery

The outcome of this was to discard 8 of the 11 options.

This left three options remaining.

Option 3 : Standalone community provider services : Social Enterprise
Option 4 : Operate as “arms-length” within local authority
Option 8 : Integration with GP Services

Further work was undertaken to consider the criteria to be used in assessing the relative strengths of each of these options against an agreed set of criteria.

A scoring system was then used to assess each of the options against the criteria. In determining the relative weighting for each of these criteria it was recognised that at this stage much of the assessment was subjective and some of the assessments could only be undertaken after a more detailed and in-depth analysis of the proposed form was undertaken. It was therefore agreed that the weightings should not significantly influence the outcome and no one criteria was therefore given undue priority at this stage. It was also agreed not to weight the affordability criteria as this is an absolute given and all final proposals would need to be tested against this.

As a result of this assessment the options were ranked in order of preference as:

- Option 3 : Standalone community provider services : Social Enterprise
- Option 4 : Operate as “arms-length” within local authority
- Option 8 : Integration with GP Services

The weightings for each criteria and the scores allocated for each option are shown in the table attached as Annex 4.

Updated Options Appraisal: September/October 2010

Since this initial work was undertaken there has been extensive review of the options appraisal to both ensure the robustness of the original assessment and in light of the revised guidance from the Department of Health.

This review has been undertaken with the financial advisers appointed to assist the Partnership with the establishment of new provider arrangements.

For the purpose of the review, the following four of the original 11 options have been discarded for the reasons given:

Option 1: Remain as is - there is no longer a “do nothing” option. The PCT must divest itself of its provider services by April 2010 (or have made substantial progress towards that)

Option 2: Standalone community provider services: Community Foundation Trust - there are no further opportunities for provider services to become a Community Foundation Trust. All applications needed to be agreed by end August 2010.

Option 6: Integration with neighbouring PCT provider services - as all PCTs need to divest themselves of provider services this can only be an option as part of another proposal around organisational form

Option 7: Managed dispersal of services - the timescale, cost and capacity required to tender services is considered prohibitive in achieving the required changes quickly. A protracted time frame for determining the future provider is a risk to the ongoing management and stability of the current services (both commissioning and providing) which could hinder the delivery of the significant financial challenges currently being addressed.

An additional option was introduced into the appraisal. This option is a joint venture with an established provider, as a partner may bring the business infrastructure and expertise to run a new organisation and may be able to supply working capital.

This leaves a long list of 8 options reappraisal which are summarised below:

- Standalone community services provider: Social Enterprise
- Operate at “arms-length” within local authority
- Integration with Royal United Hospital NHS Trust (vertical integration)
- Integration with the Mental Health Trust
- Integration with GP Services
- Integration with Charity/Third Sector
- Transfer to the private sector
- A joint venture between the private sector and the Council

It is also apparent that certain options are difficult to deliver in the timescales required for the NHS, whether this be for integrated services or just health services alone.

These are:

- Integration with GP Services
- Integration with Charity/Third Sector
- Transfer to the private sector
- A joint venture between the private sector and the Council

Against the deliverability criteria these options cannot be achieved within the timetable for the divestment of health services as under these options a tendering process will need to be established which at best would take 9-12 months to conclude, excluding a transition period for the transfer to occur.

Therefore the four options that have continued to be assessed are:

- Standalone community provider services: Social Enterprise
- Integration within local authority
- Integration within an NHS Trust - Royal United Hospital
- Integration within an NHS Trust - Avon & Wiltshire Partnership Trust

The ongoing assessment has included a review of:

- The advantages and disadvantages of each of the remaining options as undertaken in March 2010.
- The criteria used to assess each of the options.
- The relative weightings of each of the criteria.
- The scoring for each option on a qualitative basis.

Option 1: Social Enterprise

Summary

This option aims to establish a new organisation that will keep together health and social care services and staff. If this option went ahead staff would transfer to the new organisation. There is an assumption that staff working within Community Health and Social Care Services would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer took place).

A social enterprise is a business with a social purpose. It is defined not only by its legal status but also by its nature, its social/community aims and outcomes and the basis on which its social mission is embedded in its structure and governance. Its surpluses are re-invested to achieve its social objectives.

There are a number of characteristics common to Social Enterprises:

- They have explicit social/community aims and their profits are usually reinvested to achieve those objectives
- They are autonomous organisations whose governance and ownership structures are normally based on participation by key stakeholder groups e.g. staff, users,
- They are accountable to their stakeholders/members and the wider community for meeting there social/community objectives.

Social Enterprises can take many legal forms but the two most likely forms applicable to Health and Social Care Services would be:

- A Community Interest Company (underpinned by a company limited by guarantee or by shares)
- A Charity (underpinned by a company limited by guarantee)

The proposal is to ensure that whichever legal form is adopted, the governance arrangement would reflect local partnership working and would include representatives from the relevant statutory bodies, staff and the public (including Service Users and Young People).

Social Enterprise – Benefits and Risks	
Benefits	**Risks**
As a new organisation the social enterprise will have the opportunity to establish its own values and have the freedom to deliver services in the most efficient and cost-effective way to meet users' needs. There may be more opportunities for staff to be more directly involved in the development of the new organisation.	As a new organisation, the social enterprise will need to establish and maintain its viability. It would have to generate a surplus in order to be able to reinvest in the development of its services and to create financial headroom to deal with any unexpected financial obligations.
There is an assumption that staff working within Health and Social Care Services would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer takes place).	New staff coming in to the organisation may not have access to the same terms and conditions and pensions as existing staff.
There will be opportunities to further integrate services provided by the NHS and the Council to the benefit of the patient and user and to smooth the pathway of care across community and social care services.	There are costs for establishing a social enterprise and a very short timescale.
Greater independence of the organisational form promotes innovation and flexibility while allowing for the governance arrangement to retain strong involvement of the local statutory bodies and other key stakeholders especially staff, service users and GPs.	

Option 2: Integration within Bath & North East Somerset Council

Summary

This option aims to move the current community healthcare services into the local authority to have an integrated health and social care service within Bath & North East Somerset Council.

Under this model staff from health would transfer their employment through to the Council. Social Care staff would continue to be employed by the Council. There is an assumption that the health staff would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer took place). Any new staff would be employed by the Council.

Nationally, all Councils are being encouraged to consider their future role and it is becoming more likely that Councils will consolidate into predominately commissioning organisations. This option may not fit with this general strategic direction and it may result in further structural change within a short space of time.

It is also unclear as to whether the Council would be able to take all of the services currently provided by Community Health and Social Care under current legislation. Of particular relevance are services of a medical/intrusive nature. The excellent work being undertaken between the Community Hospitals and the Community Resource Centres to ensure the most effective and efficient use of the total bed base is beginning to demonstrate value added benefits to both health and social care and, most importantly to individuals. To separate these services at this time could seriously hinder the progress of this work and the real potential benefits this offers.

Given the current financial challenges facing all local authorities, the Council may not be able to take on the risk of providing health services as well as social care services at this time.

Integration with Bath & North East Somerset Council – Benefits and Risks	
Benefits	**Risks**
The Council is an established organisation operating across the Bath & North East Somerset area.	The Council is looking to save money and may not wish to take on providing health services long term and bear the risk of commissioning decisions made in future by GPs. This may therefore provide only a temporary option & there may be further staff disruption associated with subsequent organisational moves. There will still be a need for the Council to maintain its viability and meet unexpected costs and any transitional costs associated with the transfer of services.
There is an assumption that staff working within Health and Social Care Services would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer took place). Current Council staff and new staff would be guaranteed access to the local authority pension scheme and terms of employment.	NHS staff may need to change the way they work to fit in with Council procedures.
There will be opportunities to further integrate services provided by the NHS and the Council to the benefit of the patient and user and to smooth the pathway of care across community and social care services.	

Options 3 & 4: Integration within an NHS Trust

Summary

This option aims to move the current community health and adult social care services to another NHS Trust, such as the RUH or the Avon and Wiltshire Mental Health Partnership Trust. The NHS Trust would take responsibility for all the services currently provided.

Under this model staff from both health and social care would transfer their employment through to either organisation if the Council and PCT supported such a transfer.

There is an assumption that staff working within Health and Social Care Services would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer took place).

An NHS Foundation Trust is an independent Public Benefit Corporation. They remain part of the NHS but outside the control of the Department of Health. They are accountable to an independent regulator – Monitor – which oversees and monitors them and has powers to intervene. They are different from non Foundation Trusts in that:

- They are independent legal entities
- They have their own governance arrangements and local people can become members and governors of the trust
- They have a duty to consult and involve their Board of Governors in the strategic planning of the organisation
- They have financial freedoms and can borrow money
- They are free from central Government control and can set their own terms and conditions of service for staff

Neither the RUH nor AWP are Foundation Trusts at present. National Policy is that all NHS Trusts must become Foundation Trusts by 2013 and both organisations are pursuing this. Because of the changes associated with becoming a Foundation Trust and the considerable programme of change required for the health and social care community to live within its means, it is likely that the structures and systems within both organisations will change significantly. Current national policy and guidance indicates that the public sector landscape will shift significantly in the very near future.

The White Paper “Equity and Excellence : Liberating the NHS” states:

“We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundations trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.”

Vertical Integration with NHS Trust – Benefits and Risks	
Benefits	**Risks**
Both the RUH and AWP are established organisations and operate across the Bath & North East Somerset area.	This will require approval from an independent regulator and members of the NHS trust board and Members of the Council may not wish to join up with other NHS organisations. There will still be a need for the Trust to maintain its viability and meet unexpected costs and any transitional costs associated with the transfer of services.
There is an assumption that staff working within Health and Social Care Services would transfer in accordance with the Transfer of Undertakings and Protection of Employment Regulations (or the appropriate legislation at the time any transfer took place). New staff will have NHS terms and conditions as well as an entitlement to join the NHS Pension Scheme.	Council staff may need to change the way they work to fit in with NHS procedures or with those negotiated locally by the Foundation Trusts.
There will be opportunities to combine services with those provided by the Trust and to smooth the pathway of care across community and acute services.	Combining with a larger organisation could dilute the focus on the key priorities identified by the Partnership including integrating community health services with social care. Community services and those with a longer term preventative focus may find it difficult to compete for resources and attention in a large acute focussed or specialist organisation.

Assessing the options

In considering these options a number of tests have been applied. Some of these have been nationally set and others have been developed locally. These tests include:

- **Strategic Fit** – how well the proposed form could deliver the key strategic objectives of the Partnership especially:
    - Continued and greater integration of services
    - Separation of provider and commissioner functions
    - Meeting the personalisation agenda
    - Delivering services closer to home and outside of Acute Hospitals

- **Focus on Quality and Access to Services** – the new organisation needs to have community health and social care service provision as a core focus and significant part of its service portfolio to ensure the appropriate focus and priority is given to its ongoing development and maintenance of standards.

- **Efficiency** – any new organisational form must be able to demonstrate added value to existing mechanisms delivery of services in relation to cost savings and value for money

- **Deliverability** – the proposed form must be deliverable within the timescales set by the Department of Health (or shortly thereafter) preferably without the need for an interim solution

- **Acceptability** – the new form must be acceptable to the Partnership as a whole, to staff, wider stakeholders and the public

- **Governance** – there is a need for robust governance arrangement to ensure patient and service user safety, effective performance and to significant public funds

- **Sustainability** – any new organisational form must be flexible enough to respond to the changing environment and be financially viable and sustainable over many years

- **Affordability Challenges** – this includes any prima facie initial financial challenges including the need for working capital, taxation (especially VAT), pensions and pay harmonisation. These will be explored further in the relative high level financial analysis to be reported to Council and the PCT Board.

In addition to the above, the changes need to be affordable and offer value for money in relation to the ongoing provision of health and social care services in Bath and North East Somerset.

Qualitative Assessment

Based on the above criteria and a relative weighting, the preferred rating of the options and scores is as follows:

Option	Overall Qualitative Scoring
Social Enterprise	320
Integration with Local Authority	310
Integration with NHS Trust - AWP	310
Integration with NHS Trust - RUH	290

The more detailed scores are attached as Annex 1.

Risk Assessment

An initial risk assessment was also carried out on the short listed options. This is shown in Annex 2. It shows that none of the options are without significant risk if the principle of integration is to be maintained.

Conclusion

It is recognised and supported by the Partnership that the separation of the provider and commissioning functions within the PCT and the Council will strengthen both functions enormously and therefore the direction of travel proposed is supported. The timescale set by the Department of Health is extremely challenging especially in relation to the wider engagement of key stakeholders.

None of the shortlisted options are risk free and the qualitative analysis shows that although the four options are not so far apart, the social enterprise model does have significant merit in terms of more of a strategic fit and focus on the services involved than the rest of the options, although there are significant affordability challenges that will need to be overcome.

A further relative high-level relative financial appraisal of the four shortlisted options will be undertaken and reported to the Council.

The social enterprise model is one that will be explored further and a detailed financial appraisal will be undertaken prior to any final decisions being taken. Priority will be given to pursuing a model that ensures the full inclusion and representation of the local authority and other key local strategic partners in the governing and governance arrangements, including the main statutory bodies and within the domain of the Local Strategic Partnership. The specific form will need further exploration and consideration.

Assessment of Options: Scoring (October 2010)

1 = Unlikely to meet criteria; 2 = Not clear whether it would meet criteria; 3 = Goes part way to meeting criteria; 4 = Significant potential to meet criteria

Option	**Strategic Fit (20%)**	**Efficiency (10%)**	**Deliver-ability (10%)**	**Accept-ability (10%)**	**Govern-ance (10%)**	**Sustain-ability (10%)**	**Focus/ Quality (15%)**	**Afford-ability Challenges (15%)**	**Total Score**
Social Enterprise	4	4	3	3	3	2	4	2	
Weighted Score	**80**	**40**	**30**	**30**	**30**	**20**	**60**	**30**	**320**
Integration with local authority	3	3	3	3	4	3	3	3	
Weighted Score	**60**	**30**	**30**	**30**	**40**	**30**	**45**	**45**	**310**
Integration with NHS Trust (AWP)	3	3	4	3	4	2	3	3	
Weighted Score	**60**	**30**	**40**	**30**	**40**	**20**	**45**	**45**	**310**
Integration with NHS Trust (RUH)	2	3	4	3	4	2	3	3	
Weighted Score	**40**	**30**	**40**	**30**	**40**	**20**	**45**	**45**	**290**

Initial Risk Assessment of Options (October 2010)

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Strategic Fit	Change in strategic priorities of partners requires termination of approach	Medium	High	The PCT's timeline may not be followed by Council leading to reduction in support for integration. SE may not be thought a viable final model for the PCT.	Medium	High	Council may not wish to follow PCT's timeline and have limited appetite to take on community health services, so integration with LA may not be thought a viable final solution.	Medium	High	NHS body may have limited appetite for LA work and therefore may not consider this a viable solution.
Strategic Fit	Breakdown in communication between partners	Low	High	Considered unlikely due to the nature of current relationship and consensus on strategic objectives. Although there is uncertainty on how extra pressure from NHS on timeline will impact upon relationship.	Low	High	Considered unlikely due to the nature of current relationship and agreement on strategic objectives. Although there is uncertainty on how extra pressure from NHS on timeline will impact upon relationship.	Low	High	Uncertainty regarding the willingness of the Trust to take on LA work and how this will effect relations between the partners.

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Strategic Fit	Failure to move care into closer to home	Low	Medium	As the core focus for this model is the delivery of community health and social care this should not become an issue.	Low	Low	Considered unlikely as the model builds upon existing service belief in moving care into the community.	Low	Low	If AWP considered unlikely due to its services already being very community based. RUH has stronger acute focus and therefore more concern on a lack of focus on moving care closer to home.
Strategic Fit	Failure to secure greater integration of services	Low	High	Model would be a fully integrated approach	Medium	High	Model would be a fully integrated approach	Medium	High	Model could help integration between acute and community services but there is a concern that focus on integration between health and social care services would be diminished. Uncertainty regarding success of

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	Risk	Likelihood	Impact	Comment	Likelihood	Impact	Comment	Likelihood	Impact	Comment
										Section 75 to secure this.
Efficiency	Changes in model result in failure to secure value for money	Medium	Medium	SE model introduces high costs in the short term. Longer term benefits on integration will need to offset these costs. Benefits of model yet to be proven.	Medium	Medium	Pay, pension, benefits	Medium	Medium	Long term benefits on integration will need to be offset. This model does require use of Section 75
Efficiency	Lack of certainty about the potential costs of implementation	High	High	Current lack of certainty about VAT treatment and recoverability, pension costs, TUPE implications, and salary equalisation costs	Medium	High	Risk regarding pension costs and salary equalisation costs.	Low	Medium	Not as great a risk, due to the use of Section 75 for Council staff and with it being a NHS body.

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Efficiency	Harmonisation of terms and conditions leading to greater costs	Medium	Medium	Uncertainty over cost of pay equalisation and over the terms and conditions that will be given to new staff (e.g. pensions).	Low	Low	Risk regarding the potential for salary equalisation costs to impact across the organisation.	Low	Low	As an NHS body, NHS staff will not have to lose terms and conditions. LA staff will be under Section 75 and any new staff will either be recruited through NHS or LA
Efficiency	Uncertainty regarding the effect of different taxation requirements on the models	Medium	Medium	SE required to pay VAT whereas NHS and LA do not. Risk of extra financial burden.	Low	Low	This model should not present any new taxation processes.	Low	Low	Integration with NHS Trust should not change taxation
Efficiency	Cost of implementing changes will be higher than allocated resources/budget	Low	High	Estimates of establishment costs are low and are expected to be manageable within current budget allocations.	Low	High	Estimates of establishment costs are low and expected to be manageable within current budget allocations.	Low	High	Estimates of establishment costs are low and expected to be manageable within current budget allocations.
Deliverability	Changes and delays to the NHS and LA approvals process	Medium	High	The PCT would be in breach of statutory requirements	Medium	High	The PCT would be in breach of statutory requirements	Medium	High	The PCT would be in breach of statutory requirements

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
	results in failure to deliver within DH timescales									
Deliverability	Issues that arise from the due diligence process are unable to be resolved within the DH timescales	Medium	High	The PCT would be in breach of statutory requirements	Medium	High	The PCT would be in breach of statutory requirements	Medium	High	The PCT would be in breach of statutory requirements
Deliverability	LA does not wish to comply with DH timescales	High	High	The Council may be unwilling to accept the timescale pressure from the NHS and withdraw their support leaving PCT in breach of statutory regulations and with the option to construct a SE for NHS staff only.	High	High	The Council may be unwilling to accept the pressure of delivery and withdraw their support leaving PCT in breach of statutory regulations.	Medium	High	As an NHS body, the trust may be unwilling to accept the extra pressure of the process and withdraw their support leaving PCT in breach. Or the LA may withdraw their support leaving the option to transfer NHS CHS only to Trust which would not be an integrated solution.

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Acceptability	Lack of appetite for model amongst stakeholders or other partners	Low	High	Culturally and philosophically compatabile with service provider values.	Medium	High	Council concerned about the potential ongoing risk of increasing the pension liability so may not be a viable option in their view. NHS staff may be concerned by loss of terms and conditions.	Medium	High	Uncertainty regarding the LA supporting Section 75 with NHS. The NHS Trust may be unwilling to take on what is viewed as LA work.
Governance	Failure to comply with regulatory requirements	Low	Medium	Appropriate contractual arrangements would be put in place to ensure this should not occur and appropriate sanction/approaches in place to manage such occurances	Low	Medium	Appropriate contractual arrangements would be put in place to ensure this should not occur and appropriate sanction/approaches in place to manage such occurances. Also aided by building upon structures already in existence.	Low	Medium	Appropriate contractual arrangements would be put in place to ensure this should not occur and appropriate sanction/approaches in place to manage such occurances

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Governance	Restrictions on the transferability of licences render model inoperable (e.g. NHS IT systems, change in control regulations etc.)	Medium	Medium	Uncertainty over the status of delivery model	Low	Medium	Only for NHS assets	Low	Low	Section 75 covers LA staff. There is a potential risk for NHS but reduced as NHS to NHS transfer.
Governance	Legal or statutory requirements restrict or prevent transfer of assets rendering model inoperable	Medium	Medium	Uncertainty over the status of delivery model	Low	Low	[Legal advice suggests no issues]	Low	Low	[Legal advice suggests no issues]
Governance	Failure to have clear lines of accountabilit y	Medium	Medium	Suitable accountability structures should be in place to prevent this.	Low	Low	LA should already have clear lines of accountability to use as a framework.	Low	Low	Trust should already have clear lines of accountability to use as a framework.
Governance	Robust contract arrangement s are not put in place	Low	Medium	Model could only operate effectively if such contracts are in place. Suitable governance and control	Low	Medium	Model could only operate effectively if such contracts are in place. Suitable governance and control	Low	Medium	Model could only operate effectively if such contracts are in place. Suitable governance and control

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
				approaches should be in place to secure this.			approaches should be set up to secure this.			approaches should be set up to secure this.
Sustainability	Failure to develop wider market opportunities									
Sustainability	Failure to respond effectively to future changes in policy or market	Low	Medium	SE model should be flexible and able to adapt to any changes effectively.	Medium	Medium	LA is a large, well-established organisation that may find it hard to swiftly adapt to a shifting environment.	Medium	Medium	NHS Trust is a large, well-established organisation that may find it hard to swiftly adapt to a shifting environment.
Sustainability	Failure to secure initial working capital funds	Medium	High	Need to access new money	Low	Low	Council resources to draw upon.	Low	Low	Trust resources to draw upon.
Sustainability	Loss of services to competitors	Low	Medium	Integration of services should generate sufficient scale to secure sustainability. The issue could be sustaining competetivenes s in the longer term.	Low	Medium	Integration of services should generate sufficient scale to secure sustainability.	Low	Medium	Integration of services should generate sufficient scale to secure sustainability. Additionally the Trust can draw upon its acute vertical pathways as

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
										well as horizontal ones.
Quality	Poor levels of staff retention and recruitment impact adversely on operation and provision of services	High	High	Current expectation that staff may feel insecure in relation to their employment and will leave or it will prove difficult to recruit new or replacement staff.	Low	High	Uncertainty on how willing NHS staff will be to transfer to LA when they will lose their current terms and conditions.	Low	High	Uncertainty regarding how Council staff will feel going to NHS organisation under Section 75.
Quality	Loss of focus during transition on delivery of service leading to a lack of continuity of care.	Medium	Medium	Risk that with the setting up of an entirely new organisation staff will lose focus on the delivery of the service.	Low	Low	Due to integration building on existing structure, there should be minimal detraction from delivery of services.	Low	Low	Due to integration with an existing NHS body there should be minimal detraction from delivery of services,

	Option	Social Enterprise			"Arms-length" within Local Authority			Integration with NHS Body		
Risk Category	**Risk**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**	**Likelihood**	**Impact**	**Comment**
Quality	Loss of focus on core activities	Low	Medium	Considered unlikely due to the nature of the model	Medium	Medium	Provider services may be a small part of wider Council and as concept of Core Council develops it's likely to consolidate into mainly commissioning organisation	Medium	Medium	B&NES would be a small component of a bigger geographical provider which may lead to a lack of local focus.

Appendix 4

Relative Financial Appraisal – Summary PCT and Council Analysis.

	Averaged Annual Costs					
	PCT £'000	LA £'000	PCT £'000	LA £'000	PCT £'000	LA £'000
VAT	384	688	0	473	0	0
Operating Costs						
Pensions	-90	177	0	234	0	0
Corporate Governance	158	158	25	25	50	50
Estates	0	0	0	0	0	0
IT/License	0	0	0	0	125	125
Delegations	40	40	25	25	15	15
Working Capital Costs	5	5	0	0	0	0
Funding Opportunity Cost	8	8	8	8	0	0
Set Up Costs Funding	8	8	0	0	0	0
Sub Total Operating Costs	129	396	58	292	190	190
Total VAT and Operating Costs	513	1,084	58	765	190	190
One-Off Costs						
Set Up	500	500	300	300	175	175
Social Enterprise Grant	-115	-115	0	0	0	0
Existing Budget	-150	-150	-150	-150	-150	-150
	235	235	150	150	25	25

Appendix 5

Proposed Legal Form of the New Organisation

Options for the Legal Form of a New Organisation

Introduction

There is no legal definition of a 'social enterprise' although in general terms it refers to an organisation undertaking activities related to the benefit of society and reinvesting the majority of its profits into the business. There are a number of legal forms that can be used as a social enterprise, with the key forms being:

- Community interest companies limited by shares.
- Community interest companies limited by guarantee
- Cooperative societies.
- Charitable companies limited by guarantee.
- Non-charitable companies limited by guarantee.

A summary of the key characteristics of each form is set out in the Annex.

In addition to a company limited by guarantee it is possible to establish a charity as a 'community benefit society' which is a form of industrial and provident society formed under the Industrial and Provident Society Acts. Charitable community benefit societies (subject to exceptions that would not apply) have to register with the Charity Commission and the Financial Services Authority (FSA).

In order to register as an industrial and provident society the community benefit society must establish why it is not registering as a company. A company is much more widely known and understood in the market compared to industrial and provident societies and is governed by a modern legislative framework.

For these reasons, and in light of an equivalent regulation and tax regime, a community benefit model is very unlikely to be suitable and is not considered further.

The legal framework for the various forms of social enterprise are quite different and it will be important that form follows function, that is, that the PCT and the Council are clear what the key driving factors are for the new organisation and then, based on that, considers what legal form would be most suitable.

Key Requirements of the Social Enterprise Vehicle

The key criteria that alternative social enterprise models have been assessed against:

- Financial – does the form offer any financial advantages that are compatible with the social enterprise's business plan and would facilitate a more viable and sustainable model
- Distribution of Surpluses – that the form promotes the use of any surpluses into the stability of the social enterprise or re-investment in services or community objectives
- Governance – does the form offer a governance framework that is flexible and will facilitate wide stakeholder influence and effective executive leadership?

- Flexibility – will the form allow the new organisation to be flexible in how it develops and responds to what will be a very changeable market place?
- Acceptability – will the form offer any material advantages or disadvantages in terms of acceptability to stakeholders, funders or commissioners?

In light of the objectives as set out above, it is proposed, in principle, that a number of the identified legal forms can, at this stage and in light of alternative options, be set aside as not being suitable for the new social enterprise. These are:

- Community Interest Company limited by shares
- Cooperative society
- Non-charitable company limited by guarantee

This leaves a CIC limited by guarantee and a charitable company limited by guarantee as the two key models that are being considered at this stage.

The analysis below picks out and summarises the key factors considered in assessing whether a particular form would or, as the case may be, would not be suitable. Further information about the characteristics of each form is set out in the Annex and the Background Paper.

Community Interest Company (CIC) Limited by Shares

A CIC limited by shares is not thought suitable, as there is no desire for the social enterprise to distribute profit. There are three issues considered in relation to this – equity investment, rewards to staff and acceptability.

There is the question of whether the social enterprise would realistically seek to raise capital through equity investment. The business plan will not be predicated on such investment and because of the dividend caps there are serious question marks over the extent to which it would be a viable option. It is likely investors would want corresponding influence in the company, which is not consistent with the governance objectives and wider stakeholder acceptability.

Equity investment is not the only way of obtaining capital finance and the social enterprise, if established without shares, would still be able to seek to obtain performance related loans (thereby potentially achieving a stream of funding equivalent in certain respects to equity). Performance related loans would need to be compatible with the asset lock (see Annex and Background Paper).

Establishing the social enterprise in a way that could distribute profit could also raise acceptability issues, both in terms of clearing the model with the Department of Health and the NHS Business Services Authority (who would provide the pensions Closed Direction) and also with stakeholders including potential funders, commissioners and the general public.

Whilst a CIC does not benefit from particular tax exemptions it is possible for a CIC limited by guarantee to qualify for discretionary business rates relief which a CIC limited by shares does not do as it is a profit distributing company.

A key potential reason for establishing as a CIC limited by shares would be in order to qualify as an ‘employing authority’ for NHS pensions purposes thereby entitling all staff to continue to be part of the NHS pension scheme. This would only be possible if the provider service currently runs PCT Medical Services

(PCTMS), which includes a patient list. The basis for this is that the NHS Pensions Regulations include within the definition of Employing Authorities Primary Medical Contracts (PMS) and Alternative Provider Medical Services (APMS) contractors. These are defined so that only organisations which hold a PMS or APMS contract, and who are able to hold those contracts, are eligible. We understand that the PCT does not hold such a contract and it is not intended that any potential social enterprise should hold such contracts. So in these circumstances this is not a factor for choosing a company limited by shares.

In light of the issues outlined above a CIC limited by guarantee would be the more preferable of the two options if a CIC were the preferred form of social enterprise.

Cooperative Society

5.1 Historically, the mutuality requirements associated with a cooperatives society has meant it has often not been considered as a social enterprise. However, the current Government's frequent reference to the model has led to it being considered more widely in the current phase of public sector reorganisation.

In an analogous way to a CIC limited by shares cooperative members are shareholders and contribute capital and have a limited right to dividend from the cooperative. Therefore, the issues considered in respect of the CIC limited by shares (see above) would also be relevant to a cooperative.

There may also be some acceptability issues related to a cooperative, as it is possible to take the view that it is not a form of social enterprise. This is on the basis that its objectives are not to pursue activities for the benefit of a community. Rather the very essence of a cooperative is that it operates for the benefit of its members (which in this case, if say members were staff, would indirectly result in activities providing wider community benefit).

A cooperative society would require a certain governance model of open membership and one-person one vote.

The PCT and the Council require the ability to have wider stakeholder involvement and more flexibility in how the governance arrangements are structured. For example, it may be agreed that the Council will have a certain percentage of the voting rights of the social enterprise. This would not be achievable with a cooperative because it would have to have open membership and every person would need one vote. As there is no intention to distribute profits and other models (for example a CIC or charity) would have much greater flexibility on governance structures without offering material disadvantages compared to a cooperative it is not thought that a cooperative would be a suitable choice for the social enterprise.

Company Limited By Guarantee

In legal terms a company limited by guarantee would be the most flexible model as there are no prohibitions on distributing profit, no requirements about community activities, no asset lock and flexibility in respect of the governance structure.

However, in order for this form to be used in a way that is acceptable to funders, commissioners and stakeholders it is highly likely that various restrictions on

these points would need to be incorporated into the company's articles of association.

This is likely to mean that in operational terms the company would be in a similar position to a CIC limited by guarantee.

However, third parties may remain sceptical as to why this form was chosen over, say, a CIC, and why the social enterprise did not wish to be subject to the statutory framework and regulation that accompanies the CIC form.

In this case such regulation and framework is not thought to be an issue and as a result there is not thought to be merit in pursuing an option that would cause doubt in third parties and staff as to the motives and appropriateness of the structure.

Community Interest Company (CIC) Limited By Guarantee

A CIC limited by guarantee would offer a known form of social enterprise with the assurances of an asset lock and community interest test (See Annex and Background Paper).

The community interest test is quite a broad test (activities that a reasonable person would consider are for the benefit of a community) and would allow the social enterprise greater flexibility in what activities it could undertake in the future compared to a charity. The objectives of the CIC would be stated in the articles but could be changed in the future with the consent of the CIC regulator.

As a company the CIC would require directors and members, but within this framework there is considerable flexibility about the governance arrangements. The directors of a CIC are not trustees and so can be remunerated for their role and therefore be executive posts.

Membership of the CIC could be flexible with either organisations or individuals appointed and with different classes of members having different voting rights (see below for further analysis of governance options).

A company limited by guarantee qualifies for discretionary business rates relief that, depending on the policy of the Council, could be a significant financial advantage. However, a CIC does not qualify for other tax exemptions in the same way that a charity does. This may or may not be a significant factor depending on the financial model of the social enterprise.

Charitable Company Limited By Guarantee

A charitable company limited by guarantee would be a significantly different form to the others considered above with the organisation subject to the requirements of charity law and regulation. Against these additional requirements would be the financial benefits of wide tax exemptions and the potential for wider future funding streams (for example donations, grants etc).

The new social enterprise would need to have exclusively charitable objectives and provide sufficient public benefit. In this case although there is an integrated service there are still two distinct elements – health and social care.

The advancement of health is a recognised charitable purpose and as the service would be open to the general public the public benefit test should be met.

The provision of social care would fall within the charitable purpose '*the relief of those in need by reason of youth, age, ill-health, disability, financial hardship or other disadvantage'* and again as a service free at point of use and provided to the general public would satisfy the public benefit criteria.

Whilst it would seem that there would not be an issue with the immediate functions of the social enterprise the need for services to be exclusively charitable may be restrictive in the future in terms of flexibility and development of services. Whilst the objectives of a charity can be changed, the consent of the Charity Commission would be required who would need a clear case as to why it was appropriate to change the objectives.

To a degree the issues with flexibility could be overcome through use of subsidiary trading companies (a model commonly used by charities). The model works by the charity establishing a wholly owned subsidiary share company which, as a normal company, is able to undertake any activity is chooses. The charity controls the company, which can be used to deliver services that would not qualify as charitable. The proceeds from such services are then donated to the charity via Gift Aid avoiding unnecessary Corporation Tax.

A potential issue with this model, however, is that the charity must deal with the subsidiary on arms length terms and when funding activities that it could not undertake should ensure that the activity delivers a profit (as this is the only reason that the trustees of a charity should choose to undertake activities outside of their charitable objectives). Therefore if there were activities that the social enterprise wanted to undertake, but couldn't because they were not within their charitable objectives, then a trading company would only be a viable option if the activities were going to generate profit.

A key implication of a charitable model is that the persons in control of the charity – in this case the company directors – would be trustees. As such, they would not (without the consent of the Charity Commission) be able to be remunerated for their role as trustee. This would mean that there would be a non-executive voluntary tier of governance at the top of the organisation with the executive leadership operating as the senior management (and employees) of the company. It is possible to see this as either a positive or restrictive factor.

The trustees, and the charity as a whole, would be subject to the regulation of the Charity Commission, which is significantly more proactive and extensive than the CIC Regulator. The corollary of this regulation is the tax regime afforded to charities. Charities benefit from wide tax exemptions including corporation tax and mandatory business rates relief. The extent to which this is important will depend on the business model for the social enterprise.

Summary of CIC or Charitable Company

The CIC limited by guarantee or the charitable company limited by guarantee have emerged as the two most suitable models for the social enterprise.

The CIC is a more flexible model and allows for executive directors to lead the company. It is also able to benefit from discretionary business rates relief although has no wider tax exemptions.

This can be compared with a charitable company which requires voluntary trustees to be in control and which is subject to the requirements and regulation

associated with charity law. A key factor for charitable companies is the potential financial incentives both in terms of tax exemptions and future funding streams. The extent to which this is key will depend on the financial model. The last factor unknown at this stage is whether key stakeholders have a strong preference for either form.

Governance Options – CIC

As set out in Annex the governance structure of a CIC is based on the need to have members and directors of the company. The following paragraphs reflect some of initial consideration of the governance issues. Further detailed thought will need to be given to this issue as the project moves forward to implementation.

The members contain overall control of the company through key rights such as the right to remove directors and change the articles of association. However, they are not responsible for the day-to-day operation of the company, which is undertaken by the directors.

If the social enterprise will want to include stakeholders within the governance arrangements, a CIC membership will be the suitable means of achieving this. Members can either be organisations or individuals and there can be different voting rights attached to different classes of membership.

In terms of involving stakeholders it is likely to be preferable to involve relevant stakeholder organisations as members rather than individuals. This will provide continuity and will allow the accountability and public involvement associated with the relevant stakeholder organisation to funnel into and inform the social enterprise. A potential issue with appointing individuals is that the individual would need to act and vote in his or her individual capacity. For example, if the Council appointed an individual to be a member that individual would when present be acting in his or her capacity and would not be officially there to represent the Council.

Conversely if the Council were a member it could decide as an organisation (whether through delegating the task to a particular member, officer or committee) how to vote and exercise its rights as a member and then send a representative (which could differ from time to time) to exercise the agreed vote. It would be possible for different members to be given different voting rights, which could be used to ensure there is proportionate and appropriate influence in the company.

Another key stakeholder that the social enterprise will want to engage is the staff. This could be done through a variety of arrangements including all staff being members or by elected staff representatives (based on appropriate distinguishable areas of the operation) being members. This latter option would allow all staff to feed into the governance arrangements without having a very large membership that may be less manageable and effective (which could be the case if all employees were members).

It will be important to assess the response of the potentially involved stakeholders to these options as well as the rules relating to Council involvement in separate companies (with the financial position of companies over whom the Council has ‘significant’ influence being included in the Council’s accounts for prudential borrowing purposes).

In a CIC the directors will be able to be remunerated and will operate in the same way as a typical commercial company. As such, it is likely to be appropriate to have a combination of executive ("EDs") and non-executive directors ("NEDs") with best practice generally considered to be NEDs forming a majority. It will be important to have a manageable board with perhaps 9 as a suitable number. This would result in a four EDs and five NEDs. The four EDs could include the chief executive, finance director, operations director and a clinician representative. The agreed proportions and numbers would be included in the articles of association.

Governance Options – Charitable Company

As set out in the Annex the governance structure of a charitable company is again based on the need to have members and directors of the company. The following paragraphs reflect some of initial consideration of the governance issues. Further detailed thought will need to be given to this issue as the project moves forward to implementation.

The key difference with a charity compared to a CIC is that the directors of the charity will be trustees and so operate on a non-executive voluntary basis. This in many ways introduces another tier of governance as, in addition to the executive leadership (who would be the directors in a CIC), there is a need to have trustees.

Trustees could either be appointed by the membership or by outside bodies, for example the Council. This raises the question of whether the trustee level should be the tier for introducing stakeholder influence through the stakeholders having the right to nominate trustees. It is unlikely that it would be appropriate or workable for the trustees of the charity to be organisations as decision making could become very slow (which would be more of an issue at director level where more decisions and activity will be required compared to membership). Agreed stakeholders could therefore have the right to appoint directors.

In order to keep the governance arrangements manageable and avoid establishing an overly complex and conflicting structure it is unlikely to be suitable to have certain stakeholders appointing trustees from outside the company with separate stakeholders operating as members (and, amongst other things, having the right to remove directors). This would leave two broad options:

- Relevant stakeholders are not members but appoint the trustees who are also the members. This would result in one group of people being in control of the charity with those individuals appointed and removed by external stakeholders who themselves did not hold any position in the company.
- Relevant stakeholders could become members of the charity and have the right to appoint and remove trustees from this position.

It will be important to assess the response of the potentially involved stakeholders to these options as well as the rules relating to Council involvement in separate companies (with the financial position of companies over whom the Council has 'significant' influence being included in the Council's accounts for prudential borrowing purposes).

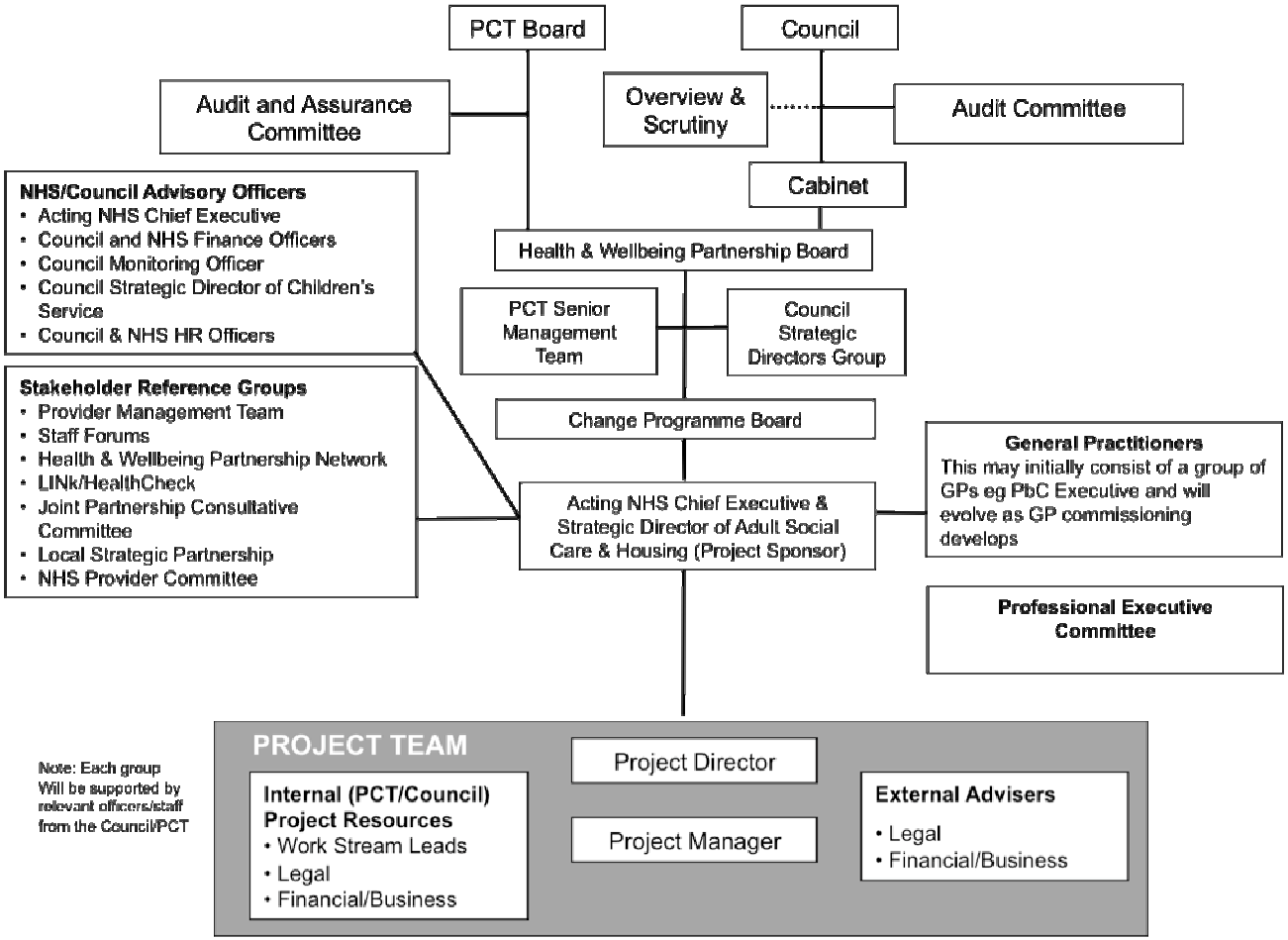
ANNEX TO APPENDIX 5

Summary of New Organisational Options (See Background Paper for Details)

	Regulators	Governing Document	Governance Structure	Distribute Profit?	Grants	NNDR Relief	Tax Exemptions	Other Key Characteristics of Form
CIC ltd by shares	Companies House including CIC Regulator	Memorandum & Articles	Directors & Shareholders	√ (Although note dividend cap)	Limited as a profit distributed organisation	x	None	Community interest test and asset lock (including dividend cap)
Cooperative Society	FSA	Rules	Members & Committee Members	√ (Although not primary aim)	Limited as profit making enterprise	x	None	One man one vote and open membership
Company Limited by Guarantee	Companies House	Memorandum & Articles	Directors & Members	x	Very limited	Up to 100% Discretionary	None	Very flexible form as no particular restrictions on activities / governance structure imposed by law
CIC ltd by guarantee	Companies House including CIC Regulator	Memorandum & Articles	Directors & Members	x	More limited than charities but still significant	1Up to00% Discretionary	None	Community interest test and asset lock.
Charity Company Limited Guarantee	Companies House Charity Commission	Memorandum & Articles	Directors & Members Directors = Trustees	x	√	80% mandatory 20% discretionary	Corporation CGT SDLT Gift Aid IHT	Subject to charity law and regulation – activities must be exclusively charitable; trustees under duty to act independently in best interests of charity and trustees can't be paid.

Appendix 6

Project Governance Structure



Appendix 7

Extract from the draft Minutes of Healthier Communities and Older People Overview and Scrutiny Panel, 28th October 2010

It was **RESOLVED** that:

1) The Panel noted the national timescale to which the NHS is required to work and acknowledged the efforts on the part of the Partnership to work within this, but remained concerned that lack of time might hamper effective decision making;

2) The Panel considered the advantages and disadvantages of the range of options presented in the report and by the contributors at the meeting;

3) The Panel supported the following range of options for the current health and social care services to be assessed:

    a. Standalone community provider services: Social Enterprise

    b. Integration with local authority

    c. Integration with an NHS Trust (Possible integration with the Royal United Hospital was discussed at some length)

    Note: The Panel want to be clear that the support for those options was based only on evidence provided at the meeting including submissions from the NHS, Trade Unions, Bath and North East Somerset Local Involvement Network and members of the public. The Panel are aware that the final decision on preferred option/s would be made at the full Council meeting on 16th November and the PCT Board meeting on 18th November. For both meetings it is expected that the report would contain more information, including financial;

4) The Panel considered and noted the principles to be used in establishing the governance arrangements should a social enterprise be chosen as the way forward by the Council and the PCT. The Panel felt that the Council and Service Users should be represented in the membership and trustee arrangements of such organisation.

5) The Panel noted the project governance arrangements and next steps and welcomed its role in the implementation of any solution prior to the establishment of any new Partnership Board under the Coalition Government's proposals as contained in the recent NHS White Paper;

6) The Panel welcomed comprehensive report from Janet Rowse (Acting Chief Executive NHS BANES and Strategic Director for Adult Social Care and Housing); and

7) The Panel welcomed contributions from the Trade Unions, Bath and North East Somerset Local Involvement Network and members of the public.