Appendix 2

ESBT future legal vehicle options appraisal information pack

Introduction

This pack has been produced to support a facilitated and open discussion on Thursday 22nd June, with the following aims:

- arriving at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future, and;
- growing our understanding of the key steps and the timetable involved for getting there.

The current learning from the UK Vanguards and the Kings Fund[1] indicates that there are a number of clear options to explore for new models of accountable care to help us deliver the future ESBT model:

- Prime provider/prime contractor 'integrator'
- Corporate joint venture (provider collaboration)
- Alliancing: commissioners and providers
- Forms of merger or new organisation

It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and the recommendation following this options appraisal will be at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will then be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. This information pack provides summarised information about the four options. Whilst not a comprehensive assessment, consideration has been given to the kinds of issues and risks that might be anticipated with each option, based on current understanding.

This information should be read in conjunction with 'The Future ESBT Model Options Appraisal Exercise' paper, which has been previously agreed by the ESBT Alliance as our approach to considering the legal vehicle options, and sets out our key criteria for assessing them along with indicators of what good looks like.

[1] New Care models: Emerging innovations in governance and organisation form (Kings Fund, October 2016)

1 High level detail, how it might work, general characteristics and risks for each option

Option 1: Prime provider/prime contractor 'integrator'

This is a commercial arrangement where a lead provider is identified that will hold the single contract with the CCGs and ESCC as integrated commissioners, and the lead provider would sub contract the services to the individual service providers within a system of accountable care.

How it might work

- There is one provider/integrator who acts as the host, holding the PACS-plus contract on behalf of other providers. The host contract holder can act solely as an 'integrator' who sub contracts with other providers to ensure delivery and performance, or they can also provide some of the services/activity themselves
- The host contractor would need to put in place arrangements to support collaborative delivery. For example this could be through forming a Provider Alliance arrangement with other providers where decision making by the providers is delegated from each provider to their member(s) who sit on a partnership Board which binds their organisations together
- Risk and reward are shared through agreed contractual arrangements, the alliance arrangement would need to be sufficiently strong to effectively pass risk and reward between the alliance partners
- The Provider Alliance would put in place a Board which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc. etc.

General Characteristics	Potential Risks
• Organisations remain separate and retain sovereignty for governance and decision-making, subject to the terms of the Alliance Agreement • High reliance on the contract to govern the relationship • Bonuses or penalties for individual organisational performance • Little sharing of assets • Time limited for a contractually specified period contract management • Clear contractual allocation of risks and responsibilities • Ease of contracting for commissioners as they are negotiating with a single provider • Easy to setup operating structure • Able to use NHS Standard Contract with minimal tailoring • Role of commissioners limited to governance of main contract • Performance management and monitoring of the sub-contracted providers is the responsibility of the prime contractor • Ability to design and deliver transformation/transition of the services is managed by a single provider • Fast decision making • Competitive tendering and procurement may be necessary	• There is limited incentive for closer collaboration or integrated care at the sub-contractor level • Primarily a risk transfer mechanism rather than risk sharing, though the Alliance Agreement could mitigate this. • Potentially too high risk to offer a fully or majority integrated contract and services via this type of contract – better suited to sub sections of services and pathways that are delivered by multiple providers. • Whichever organisation assumes 'lead contractor' role has a disproportionate amount of power and risk versus the other providers • Typically more suited to mature markets and well understood demand/services • As the prime contractor has to manage all transferred risks, this requires a provider who has experience in this role • Lack of check and challenge on prime contractor decisions • Difficult to align objectives of the prime contractor with other stakeholders in the health economy not in-scope • Competitive tendering may have a negative impact on collaborative working relationships between providers • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 2: Corporate joint venture (provider collaboration)

This would consist of key organisations such ESCC, ESHT, CCGs and potentially others forming a special purpose vehicle or other corporate joint venture (i.e. a new company) to hold a single contract for the whole population, or parts of it.

- ESCC, ESHT and possibly the CCGs and SPFT could partner in a corporate joint venture/special purpose vehicle (SPV) which holds the PACS-plus contract
- The company is established as a company limited by shares. This could take a number of forms, for example a Community Interest Company
- Control of the SPV or Community Interest Company is divided between the owning partners
- The partners in the Joint Venture would provide cash flow for the Joint Venture
- Smaller partners such as GP Federations could put in low amounts of cash flow or a nominal amount with potential consequences for their level of reward and/or control of the entity
- GPs could agree to a way of collectively representing themselves as service providers within the SPV / Community Interest Company
- Regulators would need to confirm that they are content with the approach through ISAP and/or a transaction review

General Characteristics	Potential Risks
• Keep existing separate organisational governance and add in a shared governance arrangement for the new company • Shared decision-making with agreed voting rights • A separate organisation pooling resources to deliver shared objectives • Partners each have a direct stake in the new company and shared rewards or costs • Sharing of some assets within the joint venture • Can hold contractual arrangements in its own right • Promotes a robust risk share arrangement and aligns objectives. • SPV agreement will clearly state nature, responsibilities and terms and conditions of the relationship between the parties • Ability to share the risks and rewards with partners-Incentivises closer collaboration and innovation • Access the expertise of other independent or public sector partners • Combined group of providers to create sufficient capacity to address opportunity • Single SPV entity provides clear accountability to commissioners • Legal contracting SPV structure should be sufficiently commercially defined for private sector investors to fund transformation of services	• The current statutory framework does not give NHS Trusts the power to set up or participate in corporate bodies (only Foundation Trusts are able to do this) • Substantial time and resources required in developing and agreeing the SPV agreement • Slower decision-making until all negotiations are completed • Potentially difficult to align the group of providers who have their own management style, culture and background • VAT/Tax implications • Trust between providers required to co-operate effectively • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 3: Alliancing commissioners and providers

A form of contractual joint venture, whereby the partners remain separate legal entities but objectives, incentives, sharing of risks, collective accountability and contracting for outcomes are aligned across multiple providers, which could include the CCGs, ESHT, ESCC and others such as SPFT, and allowing primary care to participate as providers as appropriate at scale.

How it might work

- The providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, a PACS-plus contract is not let instead the alliance would overlay existing contracts
- A process would be used to identify providers interested in participating in the Alliance, allowing primary care to interact as desired at scale through Federations or other arrangements
- The commissioners and providers come together in a contractual alliance to deliver PACS-plus services under their existing contracts with the commissioners
- Decision making by the commissioners and providers is delegated from each organisation to their member(s) who sit on an Alliance Governing Board on behalf of their organisation
- An overarching robust alliance arrangement which manages risk and reward sharing is put in place
- Services are delivered by the individual members under their existing contracts
- The commissioners (EHS and HR CCGs and ESCC) act as system integrators through holding the budgets and working collaboratively
- The Alliance would likely put in place a governance structure which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc.

General Characteristics	Risks
• Shared governance arrangements are overlaid onto separate sovereign organisational governance arrangements • Shared decision-making with agreed voting rights • Willingness to work flexibly to meet shared objectives • Shared rewards or costs of working together • Limited sharing of assets • The arrangement is virtual and there is no ability for the Alliance to enter into hold contracts in its own right • Contracting continues to be undertaken separately by the partner organisations • Time limited • Commissioners and providers share risk • Both incentives and risk sharing is driven by collective for meeting outcomes • Existing bilateral contracts can be retained (less disruption) • System solutions can be co-designed • Offers ability to quickly adapt to changing population/demand without need to enter formal contract variations • Ability to align objectives of Alliance with other stakeholders in the health economy not in-scope. • All parties share the Alliance agreement with common objectives and outputs -win or lose together	• Effort and resource is needed to initially develop the alliance contract. • Would be dependent on existing culture and trust -mutual trust and spirit of openness are pre-requisites for success. • Complex governance arrangements • Potential for reduced clarity on delivery responsibilities. • Commissioners retain risk or that Commissioners will exert too much influence on the Alliance and prevent the required transformation. • Tension between Commissioner/Provider wishes and 'best for Service' decision-making. • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 4: Forms of merger or new organisation

For example this could mean using the NHS Trust legal framework to form a new local NHS Health and Care Trust and create a new single health and care organisation responsible for providing the majority of services for the ESBT area. The new organisation would hold the single contract as well as sub contract with other providers to deliver the outcomes.

How it might work

- A new Health and Care NHS Trust for East Sussex is created jointly by ESCC and ESHT, and possibly the CCGs and ESHT as well. The new entity will hold the 'PACS-plus' contract as well as all other contracts for local legacy health and care services thereby creating a single 'Accountable Health and Care Trust or Organisation' for East Sussex
- ESHT and ESCC would use their powers under section 77 of the 2006 Health Act to create a Care Trust. Care Trusts have been established to bring together in one legal entity the commissioning and provision of health and social care services. Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services
- New governance and leadership arrangements are put in place which satisfy all partners and regulatory bodies
- The organisation could be built from the registered GP list to be routed in localities , with GP leadership at Governor, Board, Executive, Managerial, Hospital and Neighbourhood (Locality) level
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General Characteristics	Risks
• Single governance and decision-making • Single management structure • Full pooling of assets which can be redeployed as needed • Full pooling of the risks and rewards of different activities within the organisation • Long-term arrangement • Full flexibility and leadership over totality of resources (workforce, financial, IT and estates*)* • Evolution of a new organisation using existing provider as the vehicle is a less complex model and potentially quicker. • The other advantages are very similar to Option 1 in that a single organisation and leadership team is accountable for the governance, and delivery of the services. It offers synergies from coordinating and removing duplication from local services. • System solutions can be co-designed	• Merger could be unwieldy if it involves multiple organisations. • If merger involves an NHS Trust and NHS Foundation Trust with other providers of NHS healthcare services may require Competition and Markets Authority (CMA) review - process can be detailed and lengthy. (e.g. if SPFT were merging part of their services with ESHT) • High risk (all the eggs are in one basket), but potentially higher rewards • Limited levers of control/influence for strategic commissioners • Cultural issues • Little experience of such models in UK and limited experience of staff in leading them

2 High Level Brief Review: HR and Workforce

Our Accountable Care Workforce Group has undertaken a high level review of the four options to identify impacts and differences relating to workforce.

Key points for option 1 prime provider/prime contractor 'integrator'

- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Potentials for managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Staff comms and engagement/partnership working is vital to support retention of staff and bring about change with minimal employment relations issues.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 2 corporate joint venture (provider collaboration)

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)

- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 3 alliancing: commissioners and providers

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Staff loyalties divided between Alliance and sovereign organisation
- Employment relations issues that may arise out of similar roles but on different T & Cs
- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 4 forms of merger or new organisation

- Equity of T&Cs for new staff (and current staff once harmonisation programme/appointments process completed). Harmonisation of pensions required.
- Large scale organisational change and impact on current resources to deliver change plus impact on recruitment and retention during organisational change.
- Employment relations issues arising out of organisational change
- Managing redundancies (if they are likely to arise) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff). Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles
- Potential for large scale appointments process for local structure changes/new roles)
- OD/system development plan to support transformation

3 High Level Brief Review: digital and IT

Our ESBT Digital Programme Lead has undertaken a brief high level review of the four options and the following summarises the key differences relating to digital. Broadly speaking, when it comes to digital interoperability, the characteristic and risks for each of the four options from a digital perspective fall into two categories of organisational form:

1. Single organisation i.e. one legal entity in whatever form this takes e.g. option 2 corporate joint venture (provider collaboration) and option 4 forms of merger or new organisation
2. Separate but joined organisations in whatever form this takes e.g. option 1 prime provider/prime contractor 'integrator' or option 3 alliancing: commissioners and providers

1. Single Organisation:

Characteristics

- Removes barriers to change ("I don't work for your organisation and you can't tell me what to do")
- Simplifies Information Governance
- Removes data sharing issues wholesale as we'll no longer be sharing between organisations
- Enables and possibly requires consolidation of contracts and licensing arrangements
- Enables migration onto the same back office systems (like email)
- A single network and technical architecture
- Single IT service (service desk, support etc.)
- Single portfolio of work for prioritisation
- Single PMO and Gateway processes

Risks

- We will probably have to address some of the licensing and contractual elements as part of creating the new organisation (to avoid breaching certain legal contractual terms) which could distract from other work
- Will be complex and difficult to achieve (but ultimately delivers the most rewards for interoperability)

2. Separate but joined organisations

Characteristics

- Progress with digital integration is carried out in much the same way as the current status quo
- Easier to roll back if the collaboration doesn't work out

Risks

- Critical benefits relating to successful Accountable Care delivery (i.e. the necessity of interoperability) are harder to achieve
- Information sharing is complex and difficult
- Licensing and contract management is complex and difficult
- Federating email etc. is difficult (for example the NHS can't provide access to NHS mail to non-NHS Orgs)
- Access to each-others' systems is technically awkward
- Scheduling and prioritising work across a number of technical teams is slower than it would be with one team (although they have been doing a sterling job so far)

4 Key Public Health assessment criteria technical requirements

Our Public Health Team has reviewed elements of the criteria and indicators of what 'good' looks like from a Public Health perspective and has added the following definitions and technical requirements to those indicators, where this can be drawn out

TRANSFORMATION		Definition	Technical requirements
1 (h)	Can the option create the conditions to shift the investment in prevention, primary and community care and be consistent with the ESBT Alliance Strategic Investment Plan?	Allows a population approach to planning wellbeing and care services, using person-level and population data to organise support and care around people's needs and preferences, not those of organisations.	1. A clear link between population-level on demographic need and the planning of services and allocation of resources. 2. Ability to develop data system and capabilities that give deep understanding of the population and the skills and expertise to interrogate, interpret and communicate data. Connected, interoperable data sets that can be accessed across all care settings 3. Business intelligence systems in place that analyse health and care needs at the wider population level 4. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness
1(i)	How well does the option enable investment in prevention and early intervention and reducing the average per capita Year of Care Cost?	The form of the organisation is able to invest in prevention and early intervention, reduce transactional costs, drive out waste and improve quality to reduce costs.	1. No legal or organisational barriers to redistributing funding to most effective part of the system. 2. Clear mechanisms for identifying and comparing benefits, cost avoidance, effectiveness and savings from different parts of the system over differing time scales. 3. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness 4. Allows flexible use of capacity and capability across disciplines and organisational professional boundaries to foster shared ownership and prioritisation of prevention (primary, secondary and tertiary) across whole pathways
1 (l)	How well does the model deliver primary secondary and tertiary prevention and embed self-care and self-management to improve health and wellbeing and reduce health inequalities?	The model delivers wellbeing and care services designed to provide pathways that promote health and wellbeing, recovery and independence based on individual and population need.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Active health promotion when individuals come into contact with health and care services (making every contact count) 3. Services are designed based on patient segmentation approach 4. A specific focus on preventative services that are tailored to the needs of different communities 5. Planning services that are accessible for people with different protected characteristics and which consider the potential to generate or address health

			inequalities and which prioritise the needs of those who experience health inequalities. 6. Develop a shared preventative approach across organisations in the public, voluntary, community and private sector to deliver services 7. Model recognises and actively utilises service users as assets with an active role in improving their own health outcomes
QUALITY AND SAFETY		**Definition**	**Technical Requirements**
3 (g)	How well will the option make use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) and manage avoidable demand?	The model effectively embeds prevention, self-care and supported self-management, unlocking to the power and potential of communities to reshape the relationship between service users and health and care services.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Improving patient activation through evidence-based approaches such as health coaching, supported self-management, peer support and education programmes. 3. The six principles for effective local engagement approach are implemented 4. Linking people to community assets and other public services 5. Partnership with local government, community groups, voluntary sector, and other organisations that represent people who use services