your care your way

Full Business Case

Phase Three

November 2016

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Appendices

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1. Foreword

In January 2015, the CCG and the Council in Bath and North East Somerset (B&NES) began a joint review of community health and social care services with a commitment to be bold, be brave and be ambitious.

This Full Business Case, which sets out the case for Virgin Care to become the prime provider of community services in B&NES, is the culmination of two years of discussion and debate with a wide range of local people and professionals to understand their priorities for community services and to find the right partner to help us deliver them.

People told us they want more care closer to home. Virgin Care will organise services around GP practices to provide people with access to a wider range of health and care professionals in their local community.

People told us they want to be seen as people, not conditions. Virgin Care will place equal importance on mental and physical health, taking into account people's lives, interests and preferences to provide more holistic and personalised support.

People told us that the separation between different services can make it harder to get the right support. Virgin Care will set up a care coordination centre so people only need to make one call to access all the services that can help them.

People told us they only want to tell their story once. Virgin Care has tried and tested technology that will join up health and social care records so that everyone involved in a person's care has access to the information they need.

People told us that waiting for something to go wrong before they get the right support doesn't make sense. Virgin Care will support people to take control of their health and wellbeing to prevent ill health and reduce the amount of time people spend in hospital.

Health and care services across the country are facing a period of unprecedented challenge. The demand for health and care services is rising relentlessly as people are living longer with multiple complex conditions and we simply do not have the financial resources to continue providing services in the way we do now.

The selection of Virgin Care as our prime provider for community services marks the beginning of an essential and exciting transformation of the way we think about health and wellbeing in B&NES.

We must be bold. We must be brave. We must be ambitious.

Cllr Vic Pritchard
Cabinet Member for Adult Social Care and Health
Bath & North East Somerset Council

Dr Ian Orpen
Clinical Chair
Bath and North East Somerset Clinical Commissioning Group

2. Executive summary

This document sets out the case for Bath and North East Somerset Clinical Commissioning Group (the CCG) and Bath & North East Somerset Council (the Council) to award a contract to Virgin Care to become the prime provider of community health and social care services from 1 April 2017.

Section 3 summarises the extensive programme of engagement and consultation that has taken place with local people and professionals since the ***your care, your way*** review of community services began in January 2015. Following a series of over 80 different engagement events, a formal public consultation was held in autumn 2015 to seek feedback on a draft vision for community services, four potential service models and a set of fourteen priorities. The results of this consultation were then used in the procurement process to test how the bidders intended to deliver the priorities that matter to local people.

Section 4 explains how the procurement process was conducted and how Virgin Care was selected as the preferred bidder. It begins by setting out the reasons for choosing a prime provider model for community services, highlighting how the prime provider will hold overall responsibility for the delivery and coordination of services with the ability to sub-contract with other specialist providers to ensure that existing knowledge and experience is not lost. The section goes on to explain the four stages of the procurement process, how community champions were involved in the evaluation of bids and how the legal and statutory duties of the CCG and Council were met.

Section 5 explains how services will change with Virgin Care as the prime provider. It begins by summarising the drivers for change including the changing needs of the local population, financial pressures and the opportunities provided by technology and data. The new service model is then described in detail with a table that makes it clear how this model will address the priorities identified in the public consultation. This is followed by a description of the outcome-based accountability approach that will be used to measure Virgin Care's performance, ensuring that they deliver health and wellbeing outcomes for the whole population as well as delivering performance targets for each of the services they are responsible for.

Section 6 starts by setting out the full scope of the contract, dividing services into three groups: those to be delivered directly by Virgin Care, those to be delivered through a mental health collaboration led by Virgin Care and those to be sub-contracted to other providers. This is followed by an explanation of what will happen in the mobilisation, transition and transformation phases with specific details on how this will be monitored and funded. The section concludes with an explanation of the commissioning structures that will be put in place to support the ongoing management of the contract.

Section 7 goes into greater detail about how the transformation of services will be managed. This includes the continuity of care for service users as well as the transfer of health and care professionals from Sirona Care & Health to Virgin Care. There is a comprehensive assessment of plans for the management of estates and equipment as well as a detailed description of how Virgin Care's information management and technology (IM&T) systems will be implemented locally. The section concludes by highlighting the importance of partnership working between Virgin Care, GP practices,

the Royal United Hospital (RUH), Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) and local voluntary sector organisations and a summary of how key risks will be managed throughout the process.

Section 8 explains the financial arrangements for the contract. It sets out the financial operating model that will be used including the processes for managing risk sharing, savings and investments. There is more detail on the funding envelope, how money will be allocated in the contract and the payment mechanisms that will be put in place. The section concludes with an explanation of how taxation will be dealt with.

The document concludes with a recommendation to the governing bodies of the CCG and the Council to confirm their intent to award the contract to Virgin Care.

3. Listening to the community

Between January and December 2015, the CCG and the Council carried out a bold and ambitious review of community health and care services for children, young people and adults. The review, known as ***your care, your way****,* looked at the wide range of services providing care and support in people's homes and communities and the experiences of the people using them.

The review was based upon hundreds of face to face conversations with local people and professionals and over 80 engagement events were held to hear about their experiences and ideas. Bespoke events were arranged for seldom heard groups including young people, homeless people, BME (Black and Minority Ethnic) communities, people with sensory impairments, people with learning disabilities as well as gypsies, travellers and boaters. This included round table discussions, role play exercises, outreach events, sign language invitations and subtitled presentations.

A design workshop in May 2015 brought together over a hundred service users, carers, health and care professionals, GPs and third sector organisations to think creatively about delivering services in a more joined up way. A workforce survey in July 2015 provided further evidence of the strengths and weaknesses of the current system and how these could be addressed.

Formal public consultation was carried out in the autumn of 2015 which set out a vision for community services, four potential service models and fourteen priorities for improvement based on feedback from the engagement events. The consultation received 545 responses from a wide range of service users, carers and professionals who identified *prevention, access, timely, support, seamless* and *empower* as the most important words in the vision.

The first two models were based on a pathway approach with services organised around specific conditions or the nine functions of community services set out in our first publication, "Getting Started". The other two models were based on a community or asset-based approach with services coordinated within local communities by a GP-led Wellbeing Hub or a Community-led Neighbourhood Team. The consultation responses did not show a strong preference for one particular model but the GP-led Wellbeing Hub was the most popular model of the four with GP practices seen as a trusted and familiar presence within communities.

There was a clear indication from stakeholders that viewing people's needs in a holistic way and joining up their care were key priorities for this review. This will require two key changes:

a) Investment in the culture, skills and resources of the workforce to ensure that services provide holistic, person-centred care rather than focussing on specific conditions.

b) A technical solution that enables people and their network of support (be they professionals, friends or family) to create, share and work from a single care plan.

In addition, there was strong support for placing greater emphasis on prevention, ensuring that the right support is available to people before they reach crisis point, require hospital admission or develop a long-term condition.

Many of our current providers also indicated they are keen to work more collaboratively with each other and that there is a greater opportunity to harness the strengths of local communities, building on the resources of the voluntary sector.

The top five priorities identified from the public engagement and consultation responses were:

- A person not a condition
- A single plan
- Invest in the workforce
- Join up the information
- Focus on prevention

These priorities subsequently became the guiding principles for the construction of the tender documentation and evaluation of questions at each stage of the procurement, described in more detail below.

Further information about the engagement and consultation process can be found in *Options and Choices: Phase Two Engagement and Consultation Report* available at www.yourcareyourway.org

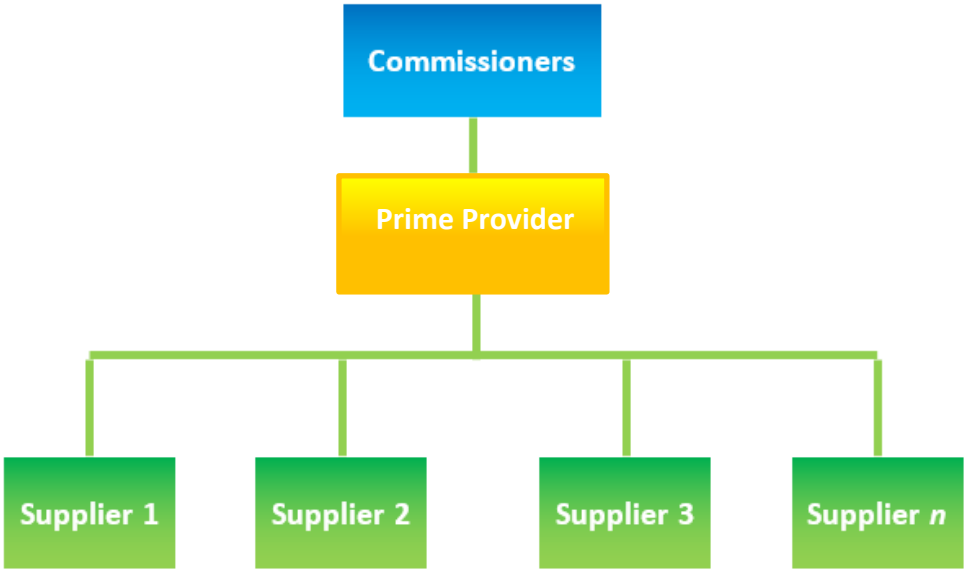
4. Finding the right partner

4.1 The prime provider model

There are over 200 different community services within the scope of the ***your care, your way*** review which are provided by over 60 different organisations. Under current arrangements, the CCG and the Council are responsible for managing individual contracts with all these different organisations.

Having identified the priorities of our local community, it was clear that a new approach to contracting community services would be required. The new approach would need to encourage collaboration between providers and reduce bureaucracy to deliver a more coordinated service for local people.

Following detailed assessment and legal guidance, the prime provider model was chosen as the best contracting method for delivering the community's priorities.



Under this model, the CCG and the Council enter into a contract with a single prime provider. This organisation has overall responsibility for the delivery and coordination of services but it can also sub-contract with specialist, third sector providers and small and medium-sized enterprises (SMEs) to ensure that existing knowledge and experience is not lost.

The sub-contracting of services will be managed through a Dynamic Purchasing System (DPS), which organisations can enter and leave throughout the lifetime of the prime provider contract. This contracting mechanism is already being used successfully for a range of Council contracts and makes it easier for small or third sector organisations to bid for contracts without going through lengthy and complicated procurement processes.

Benefits of a prime provider model

- Services can be coordinated around the needs and wishes of individuals working from a single plan.
- People will no longer need to distinguish between ‘health’ and ‘social care’ as their care and support needs will be met by a range of people and resources.
- Enables the CCG and the Council to transfer the responsibility and risk for the delivery of services to a single provider.
- Gives a single point of contact for the commissioner and vice-versa.
- Simplified governance and contract management arrangements.
- Allows appropriate emphasis on contracting for outcomes.
- Provides a single leadership structure and clear accountability for integrated working.
- Makes sure providers can directly work together, supported by the contracts between them, to ensure the pathway is as efficient and effective as possible.
- Allows sufficient flexibility to accommodate a range of payment mechanisms and incentives.
- Enables the prime provider to employ a multi-disciplinary management team and provide the IT solution for all key participants to be able to deliver the objective.

Benefits of a dynamic purchasing system

- Aligns with choice agenda.
- Does not disadvantage small or third sector organisations.
- Provides flexibility in a way that other contracting mechanisms do not, with the ability for providers to enter and leave throughout the life of the DPS.
- Allows specialisation to flourish by not requiring organisations to provide aggregated or homogenised services.
- DPS as a contracting mechanism is increasingly being used in B&NES so providers may have existing knowledge of the process.

Further information about the process for selecting the prime provider model and dynamic purchasing system can be found in the *Outline Business Case* available at www.yourcareyourway.org

4.2 Selecting the prime provider

A procurement process was undertaken to identify the best possible organisation to deliver the prime provider contract. The process was conducted in four stages (Pre-Qualification, Invitation to Negotiate 1, Invitation to Negotiate 2 and Preferred Bidder) following the timeline set out below:

Process	Dates
Pre-Qualification Questionnaire (PQQ) issued	**29 February 2016**
Advert placed	29 February 2016
Closing date for PQQ submissions	29 March 2016
Completion of PQQ evaluation and short list	14 April 2016
Issue of first round tender documents (ITN1)	**26 April 2016**
Closing date for ITN1 submissions	23 May 2016
ITN1 evaluation and dialogue process	24/05/16 – 10/07/16
Issue of final tender documents (ITN2)	**13 July 2016**
Closing date for ITN2 submissions	5 August 2016
ITN2 evaluation process	06/08/16 – 12/08/16
Preferred bidder period	**18/08/16 – 31/10/16**
Formal award	November 2016
Contract start date	1 April 2017

In addition to the priorities identified through the public consultation as outlined in Section 3, the following areas also formed part of the assessment:

- Social value
- Value for money and affordability
- Delivering transformational change

Evaluation Panel

The evaluation panel (shown in Appendix 1) was chaired by a senior member of the NHS South, Central & West Commissioning Support Procurement Team and consisted of subject matter experts from the CCG, the Council, GPs and community champions.

The community champions are B&NES residents who have direct experience of community services as service users or carers so they really understand what needs to change and what would make a real difference to their lives. They have received training and support to participate in all stages of the procurement process. This includes developing the questions given to bidders, evaluating the responses and holding a Community Question Time event to ask face to face questions to both bidders. They will continue to be involved in the transition of services to ensure the priorities of local people are delivered.

In total, approximately 50 evaluators were involved in the evaluation of bids and undertook formal training in order to do so. The wide range and experience of evaluators helped to ensure a robust and thorough evaluation process. Each member

of the evaluation panel was also required to sign a conflict of interest and confidentiality form prior to the evaluation of bids. The procurement team gave the need for confidentiality a high profile throughout the evaluation process.

As part of the evaluator training and evaluator guidance given, equity of treatment between bidders was noted as a key principle to be abided by. The ITN stages of the procurement focused on the bidders' intentions for future service provision rather than current service provision. Exactly what evaluators could, and could not, take account of in terms of their assessments was made clear at all stages.

Pre-Qualification

The service was advertised on Contracts Finder and the Official Journal of the European Union in March 2016. Pre-Qualification Questionnaires (PQQs) were evaluated fully and robustly and the following bidders were shortlisted:

- Bionical
- Newcross Healthcare Solutions
- Virgin Care
- Sirona Care & Health, on behalf of itself and;
    - Avon and Wiltshire Mental Health Partnership NHS Trust
    - Bath and North East Somerset Enhanced Medical Services (BEMS+)
    - Dorothy House Hospice Care
    - Royal United Hospitals Bath NHS Foundation Trust

Virgin Care and Sirona Care & Health both successfully progressed to the ITN1 stage. Two of the PQQ stage bidders (Bionical and Newcross Healthcare Solutions) decided to formally withdraw from the process at the conclusion of the PQQ Stage.

Invitation to Negotiate (ITN) Stage 1

The first ITN stage was conducted between April and June 2016 with the two remaining bidders as detailed above. The bidders were provided with a significant amount of supporting information in order to facilitate the submission of high-quality bids. Both bidders were shortlisted to the ITN2 stage based on a thorough evaluation process that was pre-published to bidders and available on the ***your care, your way*** website.

It was originally envisaged that the ITN1 stage would be completed in May 2016, however subsequent to the initial round of evaluations the CCG and the Council recognised the need for a significant amount of necessary clarifications prior to moving to the ITN2 stage. This included seeking references from commissioners of the bidders in other areas of the country as well as partners, service users and sub-contractors. This further clarification and moderation was conducted throughout May 2016 allowing the CCG and the Council to confidently move to the ITN2 stage with a full understanding of the two bids presented.

At the conclusion of the ITN1 stage, Virgin Care was ranked in first place.

Invitation to Negotiate (ITN) Stage 2

The ITN2 stage in July and August 2016 involved a more detailed analysis of the bidders' intentions. ITN2 responses were submitted by Virgin Care and the Sirona Partnership (submitted under the partnership name LiNK).

During the ITN1 and ITN2 stages, negotiations and other clarification sessions took place with bidders. These meetings enabled constructive, substantive and intensive discussion with the bidders to ensure their bids were as effective as possible and to ensure that any appropriate amendments to the service descriptions, evaluation criteria and financial model could be made for the next stage of the procurement.

As at the ITN1 stage, the evaluation panel was chaired by a senior member of the NHS South, Central & West Commissioning Support Procurement Team. The panel consisted of subject matter experts from the CCG, the Council, GPs and Community Champions (service users and carers with expertise through experience).

Evaluation was focused on the bidders' intentions for future service provision rather than current service provision. Therefore, the scores derived from this process are not reflective of the quality of existing B&NES service provision but are purely an assessment of the bidder's ability to deliver the future model of care, based on the information the bidder provided.

For the scored elements of the ITN2 submissions each member of the evaluation panel carried out an independent evaluation of their pre-agreed areas according to the following scoring criteria:

Label	Assessment	Score
Deficient	Question not answered, or response to the question significantly deficient. Answer does not provide satisfactory evidence as to the organisation's capability	0
Limited	A response that is inadequate or only partially addresses the question. Answer provides some evidence as to the organisation's capabilities.	1
Acceptable	An acceptable response submitted in terms of the level of detail, accuracy and relevance. Answer provides sufficient evidence as to the organisation's capability.	2
Good	A good response submitted in terms of the level of detail, accuracy and relevance. Answer provides significant evidence as to the organisation's capability.	3
Excellent	A very good response in terms of the level of detail, accuracy and relevance. Accompanying evidence is comprehensive and provides strong assurance as to the organisation's capability.	4

Evaluators' scores and comments were then collated and reviewed within moderation meetings with panel members. The meetings enabled the panel to challenge and review the scores awarded by each evaluator to ensure that scoring had been

consistent and key points in each evaluation area had been accounted for. Each evaluator was asked to provide a documented rationale or comment for their original score for each area of evaluation. The aim of the meetings was to reach a consensus score for each evaluated question.

Scoring at ITN2 was consistent between evaluators and no evaluators expressed dissatisfaction with the result of any individual moderation meeting or the scoring approach. The final moderation scoring was tested against the pre-moderated scoring to ensure no material anomalies, and none were noted.

The Virgin Care bid scored a final total of 73% of the available marks, averaging a score of '3' (Good) on the above scoring scale. The Virgin Care bid was strong throughout, with no scores below '2' (Satisfactory). It should also be noted that the Virgin Care bid scored at least equally to the LiNK bid in every individual area, with no key areas of comparative weakness identified. The final difference in score between Virgin Care and LiNK was significant, providing for a safe Preferred Bidder nomination.

Preferred Bidder Stage

The final stage of the procurement began in August 2016 when the CCG and the Council confirmed Virgin Care as preferred bidder. During this stage the CCG and the Council explored in detail the practicalities of delivering the services proposed in their bid, resolved any concerns and, most importantly, tested Virgin Care's ability to be part of an effective system, working collaboratively to deliver high quality seamless services to the residents of Bath and North East Somerset (B&NES).

The preferred bidder stage is carried out prior to moving to contract award to enable the CCG and the Council to assure themselves that the preferred bidder appointment would be safe, appropriate and result in the required services on time and in budget.

This stage focused on building and testing system-wide collaborative working and assuring the cohesive deliverability of proposed plans by:

- Concluding system-wide transition and implementation of the governance structure.
- Agreeing the expected outputs in detail including governance and project plans for the following workstreams: estates, workforce, finance, commissioning, contracting, communications and information management and technology.
- Finalisation and agreement of outcomes framework.
- Finalisation and agreement of contract terms and financials.
- Developing and agreeing system-wide communication strategy and plans.

4.3 Sub-contracting arrangements

Virgin Care will lead a process of transformation by building provider capacity and the delivery model to meet the terms of the contract and to design care pathways that will most effectively meet the needs of our population.

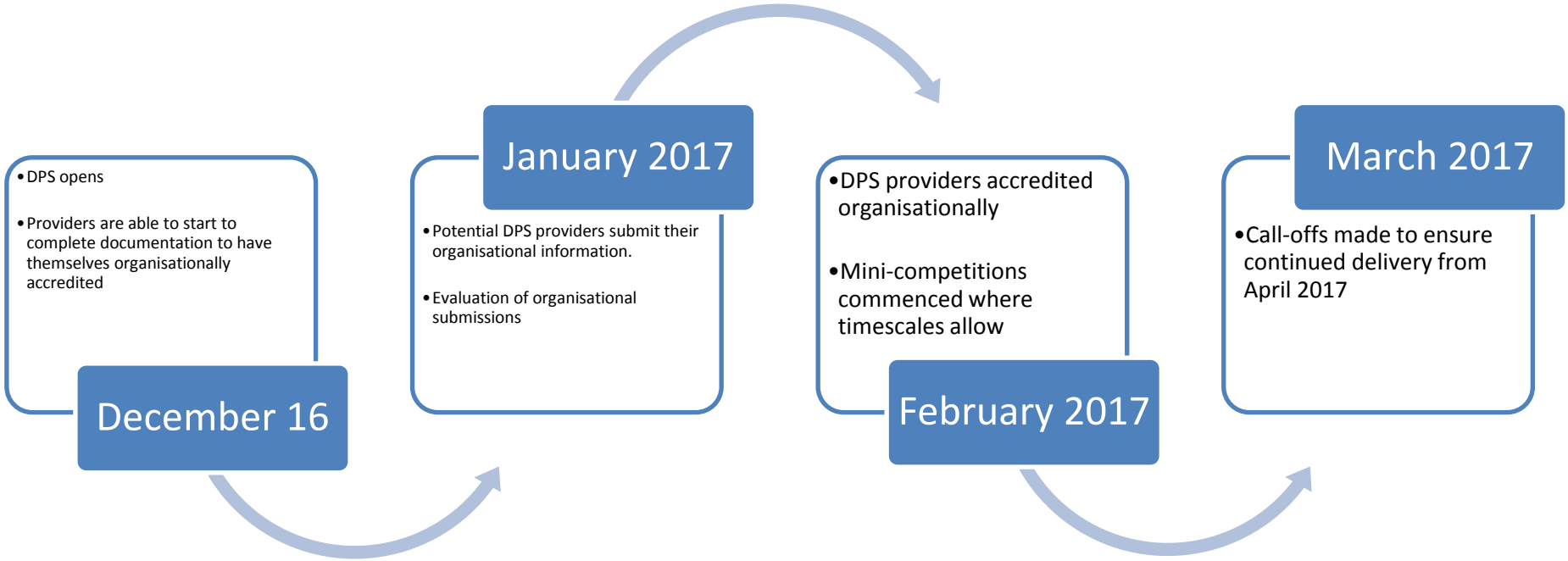
A number of services have been identified as being best delivered through a sub-contracted arrangement with Virgin Care as the prime provider as set out in Section 6

below. Arrangements for contracting with sub contracted providers within a Dynamic Purchasing System (DPS) framework will be confirmed on an individual basis with each provider in line with the particular service specification to be delivered.

A DPS is a framework the CCG and Council can use to pre-qualify any number of potential providers to deliver a service and then 'call-off' a requirement against that framework when a specific need arises. The 'call-off' against the DPS can be for a specified timeframe, for a discrete service or for any combination thereof. DPSs are flexible and simple to use, allowing new entrants to the market and enabling the CCG and the Council to react to emerging needs without going through an entirely new procurement – instead just sourcing the need amongst the pre-qualified, existing providers.

Where contracts exist past April 2017 for the above-named services, the CCG and Council will not seek to foreshorten those contracts (i.e. where a contract is currently in place to April 2018, dynamic purchasing arrangements will only apply after that date). A high-level order of events for the dynamic purchasing arrangements is shown in Figure 1 below;

Fig 1: Order of events for the Dynamic Purchasing arrangements



4.4 Meeting our legal and statutory duties

In addition to compliance with procurement legislation, it was imperative that the Commissioners considered the following areas in respect of other legal obligations placed on public sector organisations:

Duty to Involve – Health and Social Care Act 2012 – Section 14Z2

The CCG has a statutory duty to involve patients, carers and the public in the development of commissioning plans to change and develop local health services. This includes children, young people, adults, parents and carers. The right of patients to be involved in the planning and development of health services is set out in the NHS Constitution.

Alongside a range of traditional methods of engagement the CCG offered a greater range of electronic/digital opportunities to become involved. A bespoke website was created to hold all the information about the project and social media channels were used to reach a larger audience increasing awareness of the process and encouraging more people to get involved.

Equality Act 2010

The CCG and the Council had to ensure compliance with their obligations under the Equality Act. This is an obligation of substance rather than form (i.e. simply completing an Equality Impact Assessment does not comply with the Duty).
It was imperative that consultation work pre-tender identified equality and diversity issues, including specific consultation events with niche and minority groups and specific questions incorporated within any tender issued. In discharging the CCG and the Council's formal duties, an Equality Impact Assessment has been completed at the pre-award stage and is attached in Appendix 2.

Public Services (Social Value) Act 2012

The Act states that public bodies should consider (in a proportionate manner and only with regard to the specific services under discussion) how what is proposed might improve the economic, social and environmental well-being of the relevant area.

The CCG and Council must be clear in their compliance with the Act. This will be through a number of different forms such as equality impact assessments, the public consultation, financial modelling and designing the evaluation to ensure that local organisations won't be disadvantaged. Bidders were also assessed as part of the Procurement process against the three components of social value being economic, social and environmental. Specific focus was given to how the Prime Provider would:

a) Support individuals to meet their needs and wishes by harnessing the assets available within their wider community
b) Support local aspirations around the living wage, zero hours contracts and the use of temporary workers

c) Ensure that children and young people are supported to move into adulthood safely and appropriately
d) Measures that would be applied in order to assess the impact of social value outcomes

Confidentiality and conflicts of interest

At project inception the programme recognised the significant risk of potential and actual conflict of interest and took steps at all stages of the project to manage and mitigate this. The programme took into account NHS PPCC 2013, statutory guidance and the individual policies and procedures of the CCG and the Council.

The National Health Service (Procurement, Patient Choice and Competition) No 2 Regulations 2013 contain a clause on conflict of interest, and it is clear that conflict of interest was a significant risk within a project of this nature.

All procurement activity was carried out in line with the CCG and the Council's policies and procedures on confidentiality and conflicts of interest. To protect the integrity of the process, all stages of the process were treated as commercially sensitive and confidential, unless required to be otherwise.

Relevant processes were established to ensure that there are no breaches of confidentiality or conflict of interest.

Recognising, recording and being able to demonstrate the steps described above formed part of the actions taken by the CCG and the Council to mitigate and minimise conflict of interest during this tender exercise.

Act rationally and without bias

Although this is a very general duty, the procurement lead has advised the programme throughout this procurement exercise to ensure that all decisions and actions had a sound, objective basis. The South, Central & West Commissioning Support Unit (SWCSU) Procurement Team provided sound advice at every stage to ensure the programme acted proportionately, transparently and fairly at all times.

5 Feeling the Difference

5.1 Drivers for change

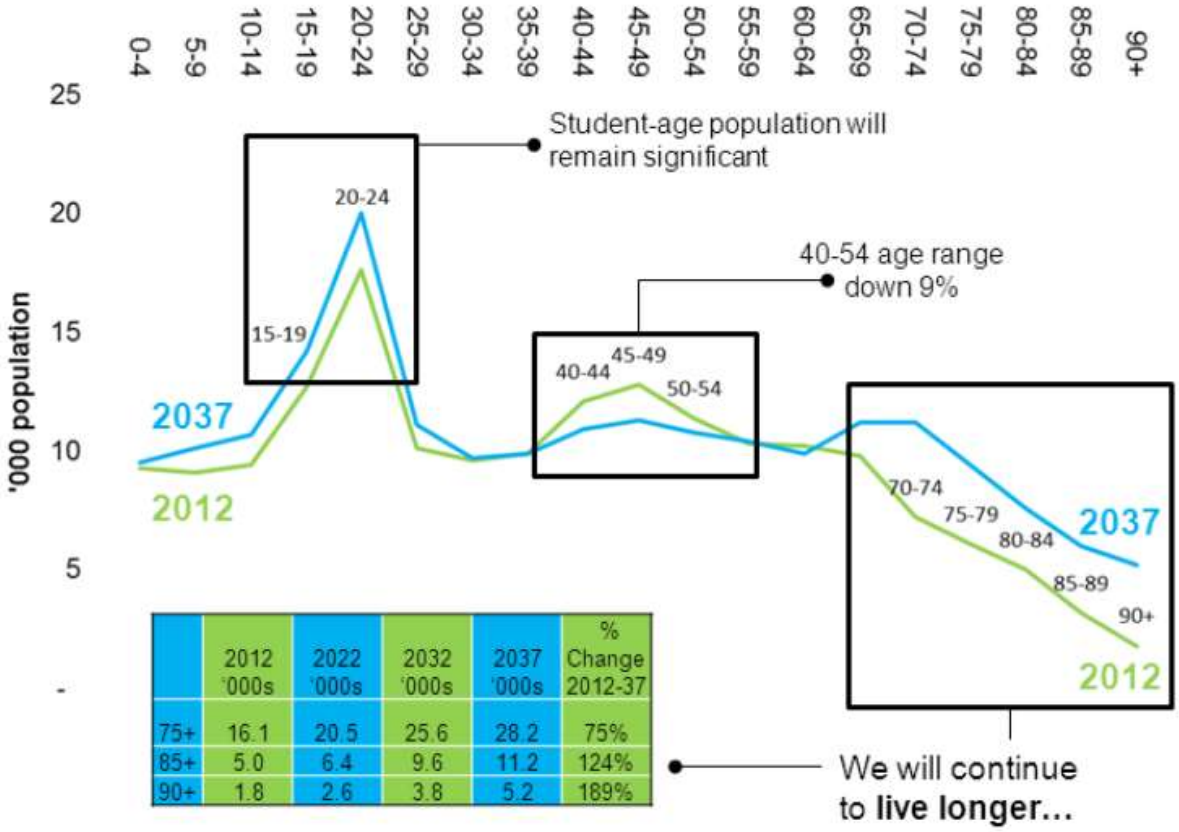
The health and social care system in B&NES is facing a challenging time. The population is ageing, the prevalence of long term conditions is increasing and the demand for health and social care services is growing. At the same time the aspirations and needs of the community are also changing as people expect more personalised services and more choice and control over how their individual needs are met.

The current financial climate also places a greater imperative on the CCG and the Council to develop models of care within available resources that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond.

The needs of our population

As defined in Figure 1 below the Joint Strategic Needs Assessment (JSNA) indicates that there will be a 12% rise in the population to 199,100 by 2037 with the number of over 75 year olds set to increase by 75%.

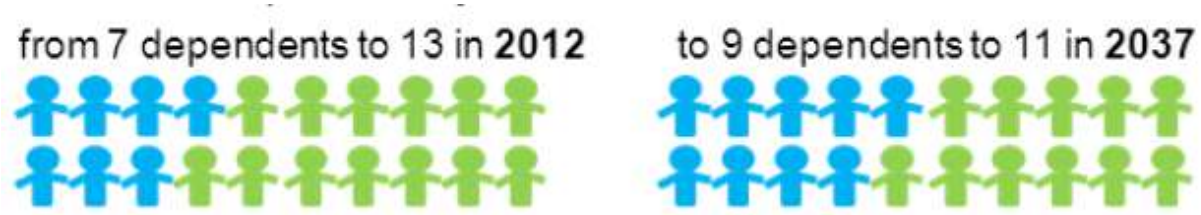
Figure 1: B&NES Population Projections



	2012 '000s	2022 '000s	2032 '000s	2037 '000s	% Change 2012-37
75+	16.1	20.5	25.6	28.2	75%
85+	5.0	6.4	9.6	11.2	124%
90+	1.8	2.6	3.8	5.2	189%

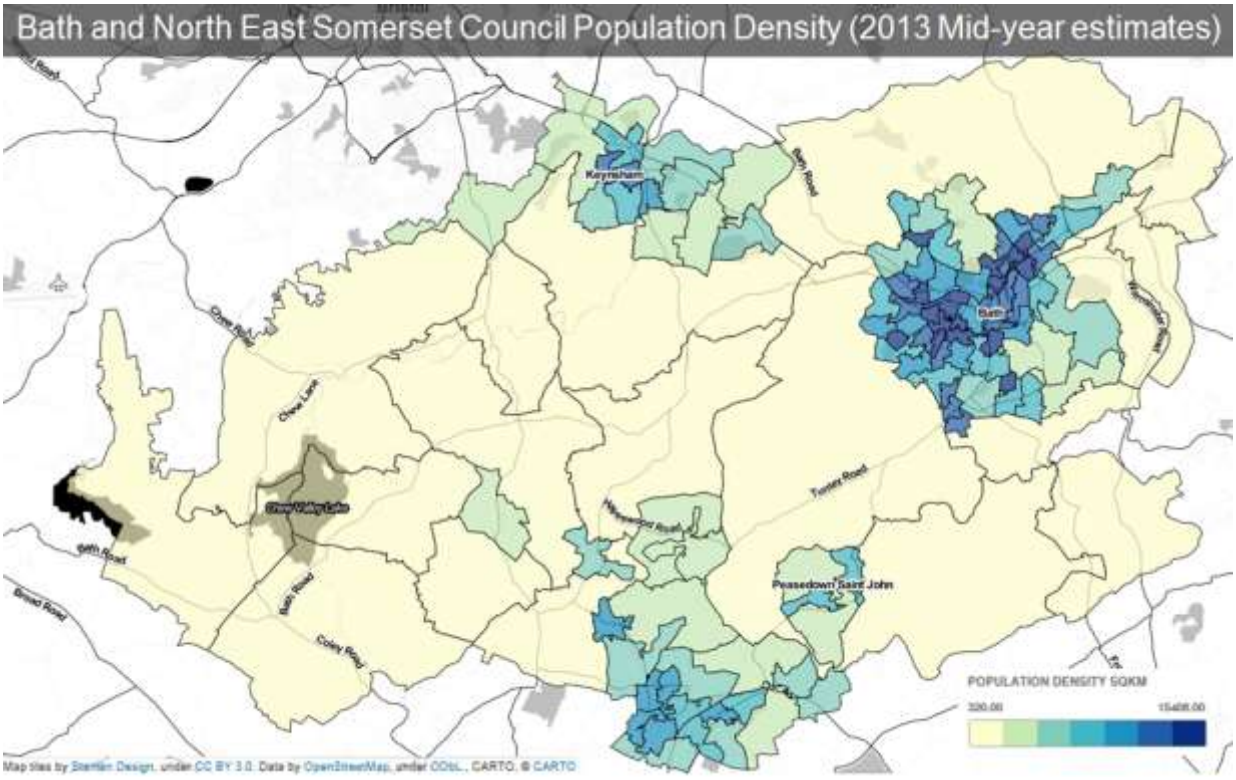
The dependency ratio of those aged 0 to 15 and 65+ when compared agsinst the working age populations is also set to increase, from a current ratio of 1:2 to 1:1 by 2037 as shown in Figure 2 below.

Figure 2: Dependency Ratio



B&NES also has a significantly higher proportion of residents (10%) aged 20-24 than nationally (7%), this can be attributed to the high student population. There are also substantial variations in population density within the B&NES area. Figure 3 demonstrates the distribution across the area.

Figure 3: Population Density



Rural communities have experienced significant social change over the last couple of decades and 14% of the local population live in dispersed rural areas or villages, this compares to 10% for England as a whole and 20% for the South West. Very often villages do not offer adequate services for the local community to access, which forces people to travel out of their community to access services such as doctor's surgeries, schools, shops and post offices. For many, private transport, either a car or taxi, is the only way of accessing these services. The increased costs of accessing services together with the increased costs of housing has led to rural living becoming less and less affordable, and for some completely unaffordable. This is particularly a problem for older people, families with young children and young people. Analysis of some of

the lowest-income households in B&NES suggests that between 8% (Chew Valley South) and 18% (Bathavon West) of residents in wards outside the city of Bath and the market towns are in receipt of income-related support or tax credits.

For children and young people evidence suggests that 12% of children in B&NES live in poverty, with 34% in Twerton, 25% in Southdown and 21% in Radstock.

With regards to people with multiple needs; it is estimated that 50% of the population will suffer from two or more chronic conditions by the age of 60, with 80% of those over 85 years suffering from two chronic conditions (and 45% of people having four or more conditions). These increased levels of co-morbidity represent a greater challenge to providing safe high quality healthcare. People will be also be frailer. Frailty is a measure of three or more symptoms from weight loss, self-reported exhaustion, low energy, slow gait speed and weak grip strength.

Section 5.2 sets out how the new service model will address the current and emerging needs of our population with an increased focus on prevention and self-management.

Financial imperatives

Historically a large element of the resource to fund community services has been allocated through block contracts through independent and joint commissioning arrangements across the CCG and Council.

In the future funding needs to be more flexible and designed around outcomes. There are a range of new approaches – the Better Care Fund is a pooled fund for health and social care designed to promote integration; the Year of Care is a new pricing approach for long term conditions; and personal health and social care budgets are designed to give individuals more choice and control.

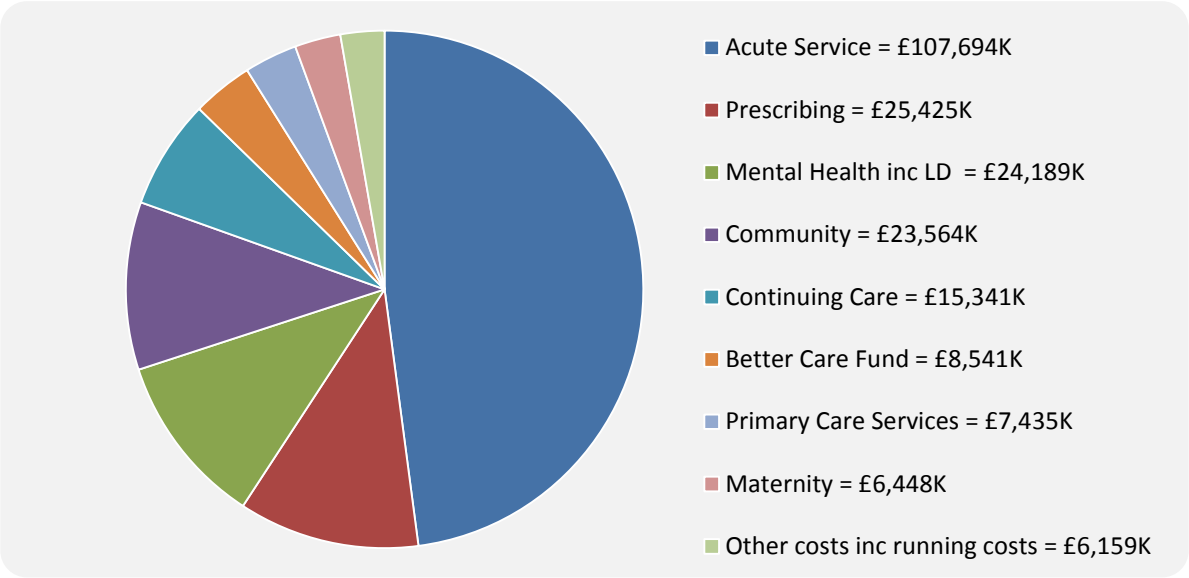
Although there is a strong drive to sustain community services as alternatives to hospital provision it must be recognised that the costs of care are rising; needs are increasingly complex and acute; and demand on services is growing. Added to that, the financial outlook for all commissioners and providers of health and care services in the medium term means they must continue to innovate and identify further efficiencies.

The ***your care, your way*** Outline Business Case set out the financial challenge that shows that both the Council and CCG will need meet the ongoing demographic challenges through more efficient working that will help redirect funding to frontline services.

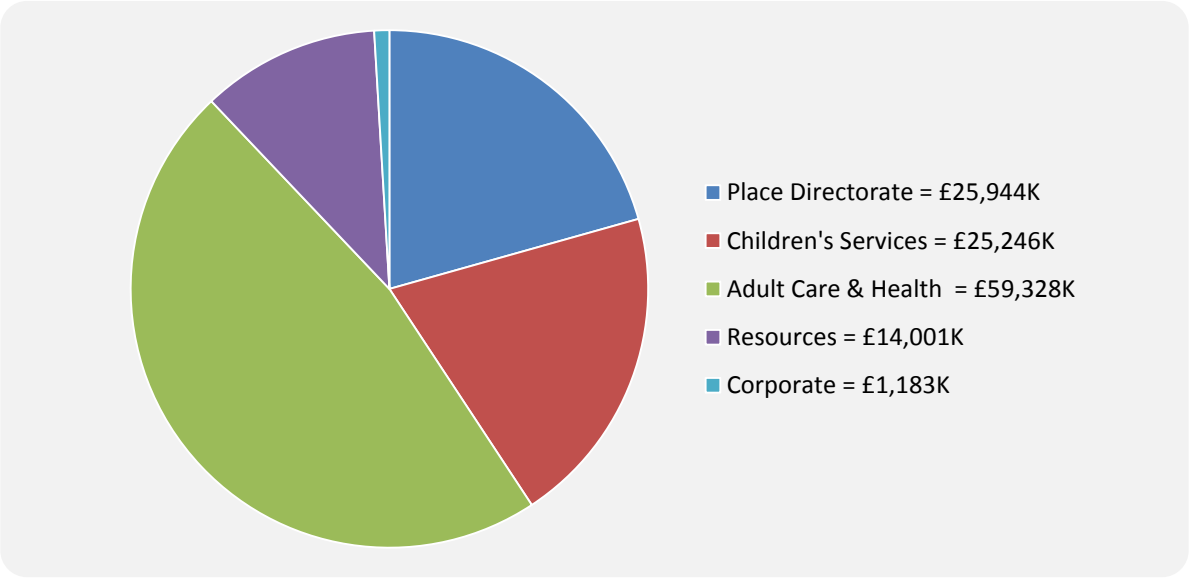
A key component of both the CCG and Council's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the most effective and safe care for people at the best obtainable value. The pie charts shown in Figure 5 below shows the outturn expenditure by organisation and type of care in 2015/16, this provides a starting point for understanding how resources are used and identifying how we can use them differently to meet the challenges ahead. Further detail on current expenditure and activity across key areas of community service provision can be found in the dashboards shown in Appendix 3.

Figure 5: Outturn Expenditure

CCG Outturn Expenditure 15/16



Council Outturn Expenditure 15/16



Planning ahead to achieve a community delivery system that has a real impact on shifting care out of hospital and delivering quality and efficient services in the community is imperative to ensure we find a way to achieve more and better services with less money.

If unaddressed, this will result in:

- More people, especially older people, being treated in hospital which does not necessarily result in the best clinical outcomes for them.

- Proportionately less money for community services as more is necessarily spent in acute care. This increases the pressure on the acute system as less treatment is possible in the community setting.
- A system focused on responding to crisis rather than preventing crisis in the first place.

The Better Care Fund requires a reduction in non-elective admission to hospital of 3.5% and a well-designed community service model can play a pivotal role in creating strong and sustainable out of hospital care.

Technology and data

Technology has a major role to play in the future of community services in B&NES. New technology allows more people to be cared for closer to where they live.

Information relevant to a person's care should be available to health and social care professionals at the time that they are caring for the individual. Information should also be available to empower an individual to take responsibility for their own care and in turn facilitate improvements in accuracy. Although the services we commission recognise that service users will move between different organisations to receive care, information that would support that care is not always able to follow the individual across these boundaries.

Clinical data is currently held in separate locations across the health and social care system in B&NES on a provider basis. The limited inter-provider record sharing that is already in place has had positive feedback in terms of improvements to clinical and social care. Significant proportions of local people receive care across a number of settings for multiple conditions. For example, 46% of people with a mental health condition will also have a long term physical health condition.

The new information requirements under the Care Act 2014 also provide an opportunity to access richer forms of data to inform service delivery and the ability for our community to have better access to their data. Providers and commissioners will need to be fully equipped and prepared for these changes so that we can take advantage of a new and improved framework of care and support.

5.2 New Service Model

The commissioned services will deliver a sustainable, preventative, planned and urgent health and care system in the local community that has a clear focus on health and care improvement, parity of esteem between mental and physical health and reducing inequalities for children, young people and adults.

The core functions for Virgin Care will include connecting services and integrating person-centred care and support that is co-ordinated around an individual's needs, wishes and preferences. Service provision will focus on the whole person, focusing on their strengths, interests, abilities and networks, not just their diagnoses, illnesses and deficits. Support will be built around individual preferences and choices and helping people to help themselves.

Virgin Care will ensure that there is engagement with local communities and partners, including people who use services and their carers, in the co-design, development, commissioning, delivery and review of local support and ensuring that leaders at every level of every organisation work towards a genuine shift in attitudes and culture. Virgin Care will incentivise and facilitate collaboration amongst providers to jointly deliver services.

Virgin Care will deliver personalised care that takes into account all of a person's strengths and needs and that of their wider support network and community. People will no longer need to distinguish between 'health' and 'social care' but understand that their care needs will be met by a range of people and resources, starting with their community.

Services will be co-ordinated to fulfil the overarching objectives of community health and care in three areas:

- **Prevention and Self-management - Living Well and Staying Well**
  Prevention and self-management services that are open to all, that promote healthy and active lifestyles and help people stay well and independent, thereby reducing health inequalities.

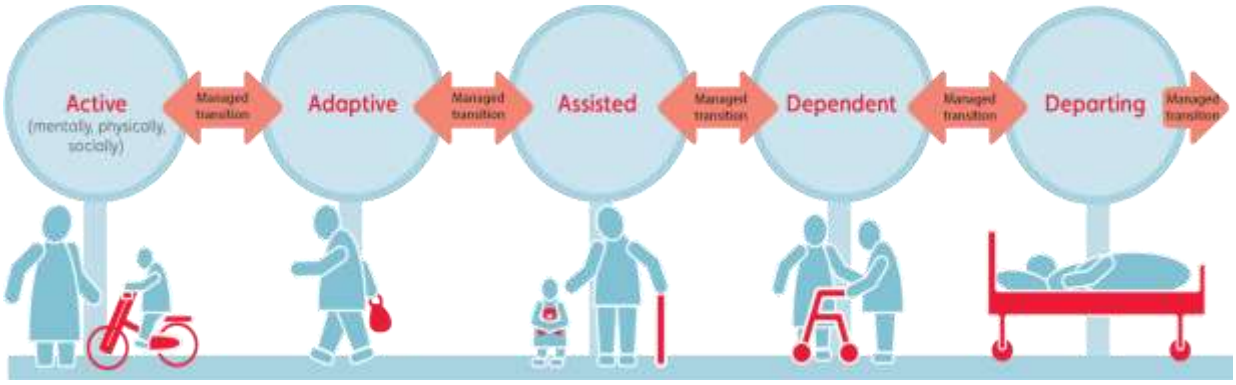
- **Early Intervention and Targeted Support - Regaining Health and Independence**
  Early intervention and targeted support services aimed at keeping people well, connected to their communities, families and friends, enabling people to regain their health and independence following a period of illness. This includes preventative, targeted activity to halt the development of a condition or a reduction in independence.

- **Enhanced and Specialist Support**
  Enhanced and specialist services will meet a person's needs where a specialism is required or where multiple agencies need to work together to meet a person's long term conditions or complex health and care needs.

Virgin Care's model is to intervene sooner in the care pathway to focus on prevention and self-management by ensuring that people have a plan of preventative and lifestyle interventions, aimed at maintaining a high level of functionality and independence for as long as possible, supported by a skilled and trusted team that is known to the person and the persons GP. People most at risk are identified and interventions put in place to reduce the risk of admission (and/or A&E contact), breakdown in social circumstances and to promote self-care.

Figure 7 below represents how the service model works, keeping people as far as possible to the left using appropriate and timely intervention as investment at this stage produces better outcomes for individuals and allows resources to be deployed most effectively.

Figure 7: Supporting needs at all life stages



Single assessments will help form the basis of a single care and support plan to give people choice and control of the care and support they receive. In particular, people with the most complex needs will benefit from many people coming together around a single support plan that is individually designed and can flex around the needs of the individual rather than the person having to 'fit in' with service requirements. There will be greater thought given to the social, psychological and economic impacts of managing complex needs both for the person and their family.

Virgin Care's tried and tested technology will pull data from existing IT systems to allow people to view their integrated care record and control how information is shared between providers and even with their own choice of friends, relatives or carers.

Community services will be organised around locality hubs, serving populations of 30-50,000 people. The locality hubs will be aligned with clusters of GP practices to ensure seamless communication and working practices with primary care. Multidisciplinary teams will communicate on a daily basis to agree coordinated plans for those with complex or increasing needs.

A new Care Coordination Centre will provide a single point of contact for people their families and health professionals. The Care Co-ordination centre will optimise service delivery by tracking people who require care and support as they move through the health and care system and guiding them to the most appropriate services.

A person's care may begin with a referral by a health or social care practitioner to the Care Coordination Centre and this will result in their onward journey being mapped out by a multidisciplinary team. Once the person has been assigned to a Locality Hub for an assessment, their ongoing management will be overseen by a care coordinator who will be responsible for arranging all their appointments, social care support and where necessary transport to and from the Locality Hub.

The Care Coordinator Centre will be operational seven days a week from 8am until 10 pm. Not everyone in the population will have their care coordinated. Several processes of risk stratification and GP recommendation will decide who is taken onto the caseload. However the broad criteria for care coordination is that there is a:

- Community health and care need
- Skilled care need

- Home based assessment need
- Change in functional need
- Opportunity for early intervention

Care Navigators from a range of voluntary and community sector organisations will be coordinated through the Care Coordination Centre to help people become aware of the range of activities that are available to them and be an important link to the integrated teams within the Locality Hubs.

Risk stratification will help to identify those who are vulnerable on the fringes of care and health or at risk – for example of admission to hospital, or of their home circumstances breaking down. The Care Coordination Centre will ensure that each person receives the appropriate intervention that best meets their needs and wishes.

This may not be a bio-medical intervention as social prescribing activities can also have a significant impact and enable people to self-care. By adopting a whole family and system approach to assessments the model will also pick up on the wider issues affecting the individual and their family. Virgin Care's Carer's network is also accessible to families for self-care support.

Quarterly educational forums for addressing long term conditions will be held to share best practice, co-design new pathways and review innovations that may support better outcomes of care and support. These forums, which will include the voice of people

with experience, will be delivered in partnership with primary, community, acute and relevant VCSE (Voluntary, Community and Social Enterprise) sector organisations to develop consistent practice and achieve better outcomes for people with long term conditions across the whole of B&NES.

A Citizen's Panel will be created to work in collaboration with providers by informing, asking and involving people who use services. Specialist pathways will be co-designed with the Royal United Hospital, AWP and local GPs, bridging the gap between acute and community care and resulting in reduced admissions, care closer to home and improved outcomes.

People will be supported to keep as active as possible and when people do become more dependent they will receive the appropriate support to regain independence quickly. As well as targeting high resource users and those "at risk", Virgin Care's analytics capabilities will identify active and adaptive people who can be assisted promptly from first diagnosis or signs of need to avoid or delay the transition from active to dependent.

Assistive technology will be used to maximise people's independence and keep them safe in their own homes. Simple, easily-managed technology that allows a person to record, report and act on their own findings at home, supported by an appropriate clinical alerting and support network, promotes confidence and has been shown to reduce the number of face-to-face consultation and emergency contacts in a number of long term conditions.

An integrated health and social care rapid response service will reduce duplication in current services and remove handovers between services. Rapid response services will prevent people being admitted to acute care by speedily providing the services they need at the right time. Technology will allow the Care Coordination Centre to monitor people's health and wellbeing in their home and deploy the Rapid Response service when required.

5.3 Addressing the community's priorities

The table below sets out how the new model of care proposed by Virgin Care will meet the priorities identified by the community in the public consultation.

Priority Area	How will the new model address this?
A person, not a condition	Services will take into account all of a person's strengths as well as those of their family, their community and their wider support network. Staff will be trained to identify people's individual goals and aspirations and will draw upon all health, care and community assets to achieve them. Staff will seek to understand any barriers to meeting these goals and work with the person to overcome them.

A single plan	Single assessments will form the basis of a single care and support plan to give people choice and control of the care and support they receive. People will be able to view their integrated care record and control how information is shared across providers and with their own choice of friends, relatives or carers. People will be involved in regular multidisciplinary reviews of their plan to ensure their physical, mental, emotional, cultural and spiritual needs are being met.
Invest in the workforce	The award-winning “People Flourish” programme will help staff improve the way they work in teams and with people who work in different ways to themselves. Investment in mobile working technology will reduce the time spent on paperwork allowing frontline staff to focus on providing high quality care. There will be a cap on management costs so that resources are invested into front line care.
Focus on prevention	Patient Activation Measures will be used to allocate people into four levels depending on their confidence, ability and motivation to self-manage. Risk stratification will help with early identification of those who are vulnerable on the fringes of healthcare or at risk of hospital admission. Rapid response services will prevent people being admitted to acute care through speedily providing the services they need at the right time. Staff will be trained in evidenced-based health coaching so that self-management is the focus for all interactions.
Join up the information	Integrated care records will pull data from existing IT systems to provide a ‘single view’ of the person. A Care Coordination Centre will provide: • A single point of contact for people who require care and support, their families and health professionals. • Signposting to other services • Booking, scheduling and case management • Single assessment • Case management • Rapid Response, Prevention, Targeted and Specialist teams • Management of Patient Portal

	• Telehealth monitoring A team of Care Navigators from a range of VCSE sector organisations will help people become aware of the extensive array of activities that are available to them.

Key milestones for the delivery of the priorities detailed are outlined in the roadmap shown in Figure 8 below.

Figure 8: B&NES Transition Roadmap

5.4 Measuring success

The CCG and the Council are planning to use an Outcome-Based Accountability (OBA) approach to plan and measure the performance of community health and social care services. This approach is a disciplined and practical framework for improving outcomes for whole populations, and also for measuring the performance of services which focus on outcomes that the services are intended to achieve.

The system incentivises interventions that add most value for individuals, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care and support across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

The advantage of this approach is that it uses a clear and common language, which will help us work together as commissioners and providers on improving outcomes. They key definitions for this performance framework are:

- **Population outcome:** A condition of wellbeing we want for our children, families, communities and population.
- **Population indicator:** A measure which helps quantify the achievement of an outcome.
- **Performance measure:** A measure of how well a service or programme is working.

Moving to an OBA approach will necessitate changes to the commissioning arrangements of the Council and CCG to ensure that there are appropriate contract monitoring and performance management structures in place, both for those services to be delivered directly by Virgin Care and those that are to be delivered through sub-contracting arrangements with other providers.

An illustrative example of how outcomes might be measured and recorded for each service specification is included in Appendix 4.

Recent legislation and policy guidance including the Care Act 2014, the Children and Families Act 2014 and the NHS Five Year Forward View all promote the concept of ‘wellbeing’ and the duty to focus on delaying and preventing care and support needs whilst supporting people to live as independently as possible for as long as possible.

The OBA approach will incentivise interventions that add most value for individuals, shift resources to community services, focus on keeping people healthy and in their own homes and deliver co-ordinated care and support across settings and regions. It will encourage a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

Community services will facilitate people and communities to come together to achieve positive change using their own knowledge, skills and experience of the issues they

encounter in their own lives. We recognise that positive health and social outcomes will not be achieved by maintaining a 'doing to' culture and believe that meaningful change will only occur when people and communities have the opportunities and infrastructure to control and manage their own futures. We will value the capacity, skills, knowledge, connections and potential in a local community and see people and communities as active co-producers of health and wellbeing rather than passive recipients of care.

The outcomes framework for community health and care services is underpinned by the Local Population and System Service Standards below:

Local Population Standards

- People will experience no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion, belief or socio-economic status.

- People are able to live free from social isolation and loneliness and feel welcomed and included in their local community and are able to make valuable contributions.

- People have a network of considerate and competent people who support them, including carers, family, friends, neighbours, volunteers as well as health and care staff.

- People have clear motivation, confidence and knowledge to help themselves to stay physically and mentally healthy and remain as independent as possible.

- People with care and support needs and/or those supporting them are aware and understand how technology can help them in their day to day lives. People are able to act on this knowledge and understanding to use technology to benefit their day to day lives.

- People feel in control of the decisions they are asked to make, either for themselves or on behalf of their family or support network. This includes all age end of life care.

- People are enabled to set achievable goals e.g. returning to work, being part of their community, regaining strength or skills that enhance their physical or mental health.

- All people, especially children, young people and vulnerable people are safe and secure.

- People are supported to become more resilient to manage risks to their health and wellbeing and know how to stay healthy and remain as independent as possible.

- People have opportunities to train, study, work or engage in other community activities that match their interests, skills and abilities, and which support their

needs, and they feel valued for the contribution that they make to the community.

- People can access support that promotes and sustains recovery and rehabilitation.

- Parents and children form strong positive attachments and parents are confident and able to meet the needs of their children.

System Standards

- People are supported to co-develop a single and personalised care and support plan that maximises their potential and enables them to self-manage their condition where possible.

- People only have to tell their story once and they know who to contact to get things changed.

- People are supported by excellent case management and professionals that work effectively together across organisation and professional boundaries.

- People receive the right response at the right time from someone they trust, and experience co-ordinated support that is based on a person centred approach that looks at all aspects of a person's physical and mental health and wellbeing.

- People continue to receive an appropriate and consistent level of support as they regain health and independence following a period of illness or change of circumstance, relevant to their level of need at the time, with no sudden or unplanned withdrawal of services.

- People are more aware of the services available to them and how to use them, including services to support wider determinants of health such as housing, transport, education and training.

- People have support systems in place to get help at times of crisis that they understand and have agreed to. People are able to recognise and plan for any future crises. When required people have a crisis plan in place and have access to crisis management, which responds flexibly to the individuals, needs as required.

Quality Framework

Quality is the guiding principle for all of our work and is at the heart of any change within community services. Quality comes in many guises but for this programme it essentially means ensuring that the pace of change and the development of pathways are seamless and are demonstrated by the delivery of local, safe, effective and responsive services which provide real benefits to people in terms of their care.

We see community services as a ‘golden thread’ that binds seamless and high quality pathways of care and support together. Involving communities in defining what high

quality means to them means providers can effectively reflect the experiences and outcomes that are important.

We will need to continue to take into account the need to balance quality with access to care and support. As standards rise and requirements such as staff to service user ratios increase, it can become increasingly difficult to maintain staff availability and/or competence, resulting in short-term changes to services. We want to make strategic decisions that ensure long-term stability of service.

During the initial phase of our engagement, we collected many examples of how organisational boundaries and an individual's transfer between organisations can cause disruption to the pathways. These include different booking systems, inconsistent methods for recording and sharing information, and communication delays between organisations that result in slower service user transfer.

In our constant striving for quality it will be important to seek to eliminate or minimise the impact of these barriers and these are further explored in the Stage One Impact Assessment shown in Appendix 2.

Benchmarking

As a national provider of over 260 contracts Virgin Care has the ability to benchmark significant datasets. These data comparisons will trigger discussion and debate around drivers for varying performance, encouraging teams to share different ways of working and developing best practice models. Outcomes will be measured at all levels (population, system and individual) using established Reported Outcome Measures tools which can be included in Integrated Care Records.

In addition to the above, Commissioners will continue to use available local and national benchmarking data to help shape and inform future plans.

Monitoring

Alongside the new model achieving the required outcomes for the people and communities, the needs assessment shows it is necessary to manage increased demand driven by an increasing population and recognise the need to deliver services sustainably into the future within the budget available. At the beginning of each year the indicative levels of activity required for each service will be agreed between the CCG, the Council and Virgin Care and monitored across the year. Virgin Care's bid includes improved information gathering and sharing so that we will be able to monitor the number of people accessing the services and the quality of support they receive both for individual services, multiple services and to support understanding of the demand / capacity and ongoing sustainability of the model.

5.5 Contract Governance and Performance Management

The Prime Provider will be responsible for high-level system leadership of the overall delivery model, ensuring effective coordination and collaboration between providers and across localities, promoting the sharing of best practice. Other key responsibilities include;

- Monitoring outcomes for the local community and for co-ordinating input and activity to deliver the contract whilst ensuring appropriate governance, quality assurance and engagement with patients or service users.

- Bringing together senior representation from providers, primary care, secondary care, public services, VCSE organisations and the local community (supported by subject matter experts and community champions).

- Embedding appropriate measurement systems in place in order to measure their own performance and that of any subcontracted partners against performance measures agreed with the Commissioner.

- Reporting on performance measures to the Commissioner against an agreed schedule.

- Implementing mechanisms for managing risk, including disaster recovery, contingency and business continuity plans. The Prime Provider will keep the Commissioner informed about detail of the risk management structures and processes that exist, and how they are implemented.

- Establishing a system to analyse the type, frequency and severity of adverse incidents, in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements.

- Promoting a culture that encourages and supports staff to report adverse incidents.

The Prime Provider will meet regularly with the Commissioner to review performance. Measures may be revised over time to understand and meet changes in demand, and to reflect the development of local minimum data set requirements. The Prime Provider will be required to produce regular summary reports providing full details of all complaints and how they were resolved.

6 Making it happen

6.1 Scope of the contract

The health and care system in B&NES is complex with a wide range of services commissioned by the CCG and the Council to provide care and support for local people. To achieve our objective of integrating health and care services for all ages we considered the broadest set of services that could fall within the scope of the prime provider contract and conducted service by service assurance based on the following factors:

- Current interdependencies including co-commissioning arrangements and interdependencies with other services and pathways
- Virgin Care's proposed positioning of services
- Impact on the local market
- Service transition issues

We have also considered the optimal positioning of services within the prime provider model with regards to:

- Benefit to the service user
- Promoting the integration and joint delivery of health and care services
- Alignment of services to the core functions and duties of the prime provider
- Ability for the prime provider to deliver service transformation at population level
- Interdependencies with other health and care services and pathways

The full scope of the contractual arrangements is set out below, separating out the services to be delivered directly by Virgin Care and those to be delivered by material sub-contractors, in partnership or through DPS arrangements.

Services to be delivered directly by Virgin Care (or in partnership with nominated providers)

Many of these services will be delivered as an integrated health and care service with clinicians and specialist practitioners working alongside each other in integrated locality teams. It is therefore appropriate to locate them within the same prime provider.

In addition, a significant number of people, particularly those living with long term conditions or complex needs, will be accessing a range of services at any given time and the need to deliver joined up care and support, working to a single plan, is paramount.

Transferring the services to Virgin Care will allow them to establish a system leader role within these services which will include: establishing visibility and credibility with other providers; leading on service redesign; driving transformation; ensuring benefits are realised by the wider community; promoting the delivery of integrated health and care services, particularly for people with complex and specialist needs; establishing a high standard of clinical effectiveness across all health and social care services.

Although Virgin Care will be delivering the following services directly they will be subcontracting some elements of these services to other providers. The number of services directly provided by Virgin Care may also change over the life of the contract.

Statutory Services	
PD1	Adult Social Care Statutory Services
PD2	Continuing Healthcare
PD3	Children's Statutory Services
Non-Statutory Services	
SD1	Public Health Nursing
SD5	B&NES Community Children's Health Service
SD7	Children's Bladder and Bowel Service
SD8	Children's Community Nursing and Psychology Service
SD9	Children's Continuing Care
SD10	Children's Learning Disability Service
SD12	Children's Speech and Language Therapy
SD13	Community Based Adult Audiology and Hearing Therapy Service
SD15	Community Bladder and Bowel Service (Adults)
SD17	Community Hospital Inpatients
SD19	Community Nursing (Adults)
SD26	Falls and Movement Disorders
SD31	Integrated Reablement Service
SD32	Integrated Sexual Health
SD35	Lymphedema Nursing
SD36	Medicines Optimisation
SD38	Physiotherapy Services
SD40	Orthopaedic Interface Service
SD42	Paediatric Audiology Service
SD43	Adults with a learning disability
SD46	Specialist Cardiac and Respiratory Service
SD47	Specialist Diabetes Service (Adults)
SD48	Specialist Neurology and Stroke Service (Adults)
SD49	Speech and Language Therapy (Adults)
SD51	Urgent Care facility at Paulton Community Hospital
SD53	Youth Offending Service Nurse
SD54	Podiatry Services

Services to be provided by a mental health collaboration led by Virgin Care (subject to pathway review led by the CCG and the Council)

The due diligence process has highlighted the need to give further consideration to the positioning of mental health services, particularly those currently provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and their relationship with Virgin Care as the prime provider.

The CCG and the Council recognise the benefits of the B&NES Mental Health Collaboration but there are some further areas of due diligence that will need to be considered before confirming the final position of the service. These include the ability to build on the adult acute care pathway work recently commenced across six AWP localities and effective management of step-up and step-down care into and out of inpatient facilities.

The CCG intends to be party to the co-commissioned two-year contract for AWP services, led by Bristol CCG, which will begin in April 2017. This contract includes the following services, which will be delivered by AWP in partnership with Virgin Care:

SD20	Community Mental Health Services for Older Adults and those with Dementia
SD33	Intensive Service
SD37	Mental Health and Wellbeing Recovery Service
SD44	Primary Care Liaison Service
SD45	Primary Care Talking Therapies Service
SD56	Early Intervention

However, it is likely that changes to the way the service is contracted will need to be implemented during the life of the contract in line with the final agreed arrangements for community health and care services.

In 2017/18, the CCG and the Council will begin an end-to-end pathway review to determine the best arrangements for delivering the full range of community and acute inpatient mental health services across health and social care including provision for both children and adults.

Services will be developed within the proposed B&NES Mental Health Collaboration which will be led by Virgin Care with the full participation of all other members including a combination of voluntary, community and social enterprise (VCSE) organisations.

Services to be sub-contracted from Virgin Care to other providers

A number of services and service providers have been identified as being best delivered through a subcontracted arrangement with Virgin Care. The factors that have been taken into account include:

- The proven track record of the provider in service delivery for the particular service
- The local or national expertise of the proposed subcontracted partner in the particular field
- The current arrangements for delivery of services and quality of provision
- The ability of the provider to work alongside Virgin Care to maximise the strengths of the voluntary sector, local communities and small and medium enterprises.

Arrangements for contracting with sub contracted providers within the Dynamic Purchasing System (DPS) framework will be confirmed on an individual basis with each provider in line with the particular service specification to be delivered.

SD2	Adult Carer's Centre
SD6	Care at Home Service
SD11	Children's Occupational Therapy and Physiotherapy Service
SD14	Community Based Mental Health Pathway
SD16	Community Equipment
SD18	Community Opportunities for Older People Who are Living with Dementia
SD22	Dementia Support Service
SD23	Direct Payments and Personal Budgets
SD24	End of Life
SD25	Extra Care Housing Services
SD27	Home from Hospital/Home Response Service
SD28	Housing Related Support Homelessness Prevention Services
SD29	Housing Related Support - Positive accommodation and support pathway
SD30	Independent Living Service
SD39	NHS Health Checks Programme
SD50	Substance Misuse
SD52	Wellness Service - Lifestyle and Wellbeing Support

Note: SD4 Advocacy has been taken out of scope of the prime provider contract to ensure that commissioned services are separate from any of the service delivery functions so that service users have independent access to support and guidance.

6.2 Mobilisation, transition and transformation

Implementation of the new model for community services will be broken down into the following three phases:

Mobilisation

Virgin Care has extensive experience and a 'tried and tested' approach when mobilising adults and children's community services, transferring over 250 services over the last ten years.

Successful mobilisation can be measured by the following criteria:

- Clear referral guidelines and pathways
- Ongoing engagement with referrers including training/feedback/advice
- Introducing a single-point-of access for referrers through a Care Coordination Centre to create a speedy and seamless pathway of care
- Reduced waiting times and convenient community locations
- Close links with primary care and secondary care
- Strong relationships between providers and commissioners and demonstrable value for money
- Integration which blurs the boundaries between health and social care, offering users a seamless pathway of care and support

A detailed mobilisation plan can be found in Appendix 5 which sets out the key milestones to ensure the service is operational by 1 April 2017.

A dedicated mobilisation-team will be assigned to work with the services and the CCG and the Council, who focus on due diligence and the transition into and out of safe transfer. The team will oversee the mobilisation plan with clear milestones linked to a risk register to ensure the service is successfully operational within the agreed timeline. Commissioners will use an adapted Department of Health approved

“Statement of Readiness” check, an organisational tool that is utilised for all services before they are launched.

Subject to approval of this Final Business Case, Virgin Care will;

- Refresh the mobilisation plan, updating any timelines, resources or milestones and finalise it in conjunction with the commissioner
- Create a Project Office and arrange a kick off project briefing
- Initiate contract completion activities
- Continue necessary due diligence activities
- Initiate TUPE plans
- Roll out customer service training for the single point of access that has already been developed by Virgin Care’s internal Training and Learning Enterprise (TLE)
- Continue with the business as usual to ensure system flow, capacity is not affected as the services are mobilised
- Ensure that the CQC compliance is maintained through the registered managers within the service

From contract award to first day of operation (Day 1) Virgin Care will:

- Agree contract signature with the CCG and the Council
- Carry out detailed due diligence
- Mobilise the Operations Team and Work stream leads who will ensure safe delivery of the service during Mobilisation and Transition. This will be headed by the Virgin Care Regional Operations Director, who will oversee all teams and liaise directly with each work stream lead
- Have all pathways prepared for Day 1
- Procure any assets agreed with the CCG, the Council and other partners
- Identify unfilled posts that are critical to service continuity and development
- Commence a recruitment campaign both locally and nationally to fill outstanding vacancies. This will include Virgin Care’s national recruitment strategy with NHS jobs as well as local recruitment such as advertising on B&NES Council website and the Bath Chronicle
- Prepare launch and media activity for Day 1. Media related activity will be coordinated with the Council and CCG
- Create a dedicated website for local service information
- Confirm continued access to terms and conditions and pensions for current staff
- Positively engage with trade unions and other representative groups including RCN, UNISON, UNITE and BMA
- Confirm which contracts will continue, cease and which need to be created
- Follow staff welcome pack process and send out key information to staff on the ground
- Newsletters and staff briefings early on, following award of the contract, this will complement the monthly newsletter staff already receive.

Transition

Virgin Care consider safe transfer to last up to the end of the first 100 days of service (July 2017), and during this period the priority for will be to ensure that all services have transferred safely and any challenges identified during transfer are resolved. Further priorities during transition include;

- Transfer to Virgin Care policies and procedures; this work will include establishing a new service-wide reporting framework, governance protocols and implementing new policies.
- Supporting the workforce; ensuring that colleagues transferring understand the vision of ***your care, your way,*** and have a say in how the roadmap is developed. Immediate priorities are to identify training needs, a leadership and change programme.
- Working with partners; Virgin Care will be working over transition to support other health and care organisations, to support developments within the STP and to start to integrate data of other providers with their own.
- 'Deep dives' of high priority areas; identified during due diligence services that require further assessment of pathways will be prioritised for redesign and any urgent remedial actions undertaken
- Communication; establishing the 'citizens panel' that will be the forum for ongoing engagement will take place during transition and terms of reference agreed locally.

Transformation

Virgin Care have proposed that transformation will take up to three years of this contract, due to the size and breadth of re-design that is required. The priorities for transformation have been outlined on the roadmap shown in Section 5.3, to illustrate how each of the principles in ***your care, your way*** will be delivered. In addition, services for immediate transformation have been identified in conjunction with Commissioners. These are services that require urgent performance improvements or those that have a significant impact on other health and care services, such as Continuing Health Care. Transformation plans will be agreed in conjunction with Commissioners and supported by a dedicated Virgin Care transformation team, working alongside operational leads to ensure that transformation is delivered. Other key priorities for year one include;

- Establishing relationships with key partners including; Primary Care, RUH, AWP and Voluntary, Community and Social Enterprise Sector organisations
- Embedding of Multi-Disciplinary Team process
- Interoperability and integration of health and care record
- Establishment of Citizens' Panel
- Consultation in relation to locality hubs

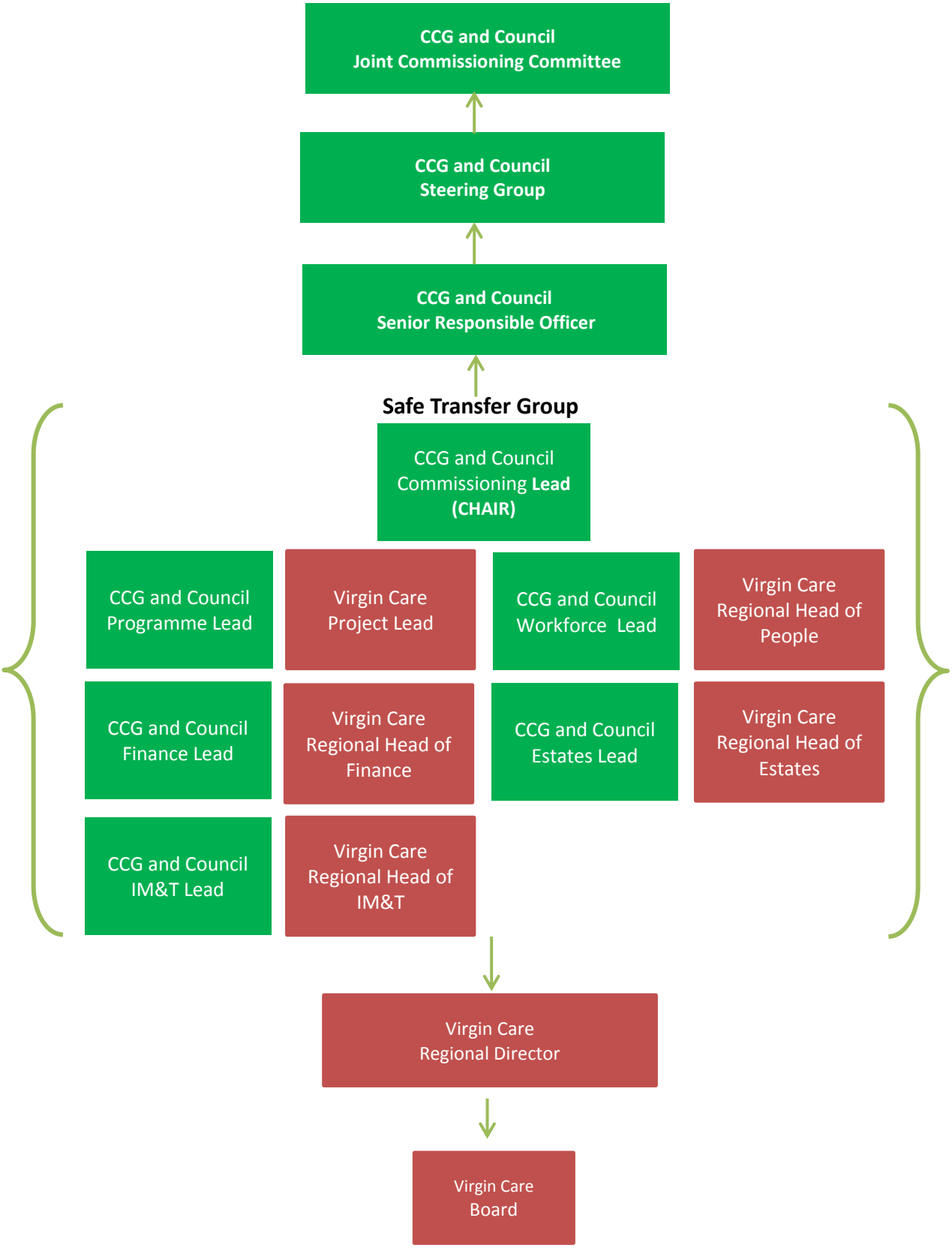
6.3 Monitoring progress

The Safe Transfer Group will oversee all mobilisation objectives and provide regular progress updates to all stakeholders including service users, providers and the wider public. The group will meet weekly to review key risks and assess progress against key objectives.

The Safe Transfer Group will provide a formal update of progress and a 'Top 10 Risks' report to the Steering Group which will consist of senior managers from the CCG and Council. The Steering Group will provide assurance to the Joint Commissioning Committee that mobilisation is on track and deal with any issues that cannot be resolved directly by the Safe Transfer Group.

This governance structure (shown in figure 9 below) will ensure that any mobilisation difficulties can be resolved swiftly and by mutual agreement.

Figure 9: Safe Transfer Group



Sitting below the safe transfer group are the Mobilisation Workstreams (see Table 1 below) made up of operational and mobilisation experts across Virgin Care, the CCG and the Council. In addition, Virgin Care will also attend Procurement Programme Board and Clinical Reference Group meetings as required.

Table 1: Mobilisation Workstreams

Workstream	Responsibilities
Transformation	To lead mobilisation, direct mobilisation team and operate as the point of contact for commissioner
Commissioning	Operational accountability and service continuation, continued focus on business as usual within mobilisation/transformation. Information cascade and operational meetings with staff groups both for business as usual and mobilisation / transformation. Initiation of service design and transformation activity.
Finance and Commercial	Continuation and delivery of all financial related tasks. Establishment of working arrangements with partners, support Transformation Lead through contract negotiations
Legal	Contract signature, establishment of new contracts. Liaison with Virgin Care legal team.
Workforce	Recruitment, staff events and launch activities. Point of contact for all staff concerns/queries.
Communications	Development and implementation of communications and engagement strategy, implementation of GP engagement plan.
Clinical Governance	Responsible for safe delivery of services during Transformation. Support and review introduction of new pathways of care.
Estates and Information Technology & Management (IM&T)	Set up of new occupancy agreements and initiation of estate review. Set up of new infrastructure and continuation of current systems. Information governance and data transfer

6.4 Funding transformation

Whilst the majority of change management costs will be met by the Prime Provider, it is anticipated that the Council and CCG will incur internal costs to fund specialist resources to support the mobilisation and transition process. These are Council and CCG funded non-recurrent costs to cover all of the significant work areas required and are critical to supporting transformation at scale.

These costs are indicative and representative of external resourcing to support transition and the service transformation required to deliver the new model of care that will meet the Councils and CCG's strategic objectives. Resources include subject matter experts covering areas such as;

- Programme Management and Governance to embed to manage the change programme and embed contractual governance frameworks and;

- IT infrastructure experts to ensure that locally we are able to support delivery of an integrated care record and enhance access to care records for people in B&NES. This will support delivery of good quality care, by for example, ensuring access to an integrated care record that ensures a single view of the person and also enabling increased direct face to face contact.

Where possible both the Council and CCG will make use of internal resource that is funded from existing budgets, however, due to the size and scale of the transformation challenge it is anticipated that external support will be also be required. The approval of additional funding will need to follow the Council's budget management scheme and the CCG's financial planning approval process.

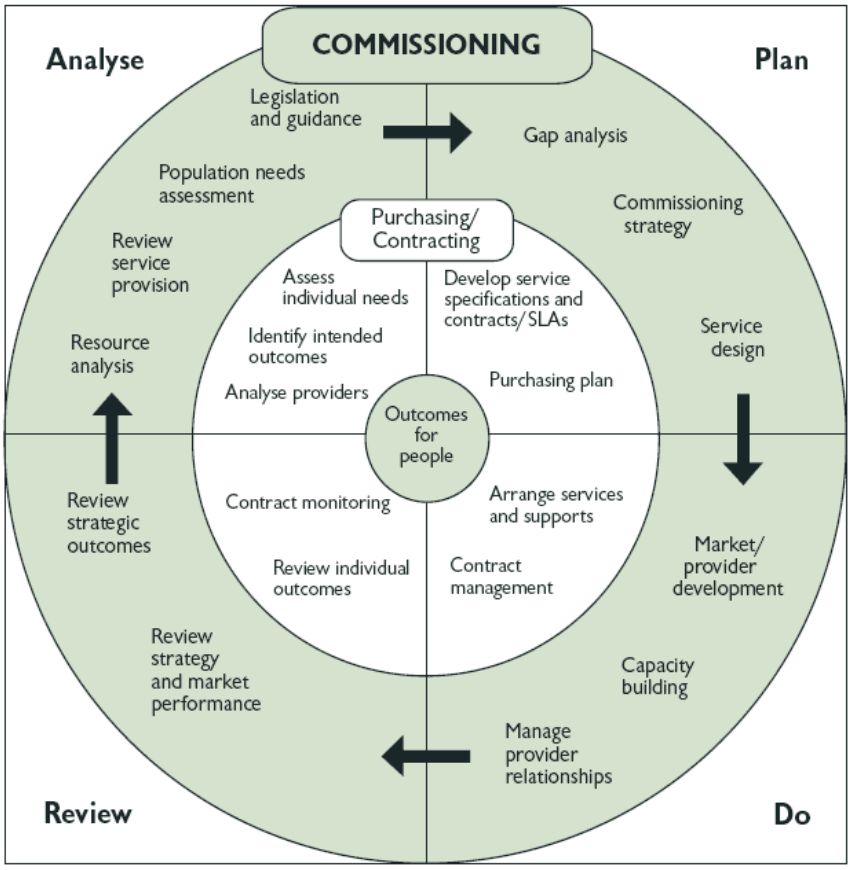
Table 2: Resource Transformation Costs

Description	Cost
Programme Management and Governance	£150,000
Information Management &Technology Specialist Support	£200,000
Finance Specialist Support	£70,000
Estates Specialist Support	£50,000
Workforce Specialist Support	£50,000
Communications	£20,000
Total	**£540,000**

6.5 Commissioning structures and ways of working

The commissioning landscape is changing. In addition to the creation of a prime provider for community services in B&NES, there is the need for collaboration on a number of fronts. For example, within B&NES, as well as established partners like the Council and CCG, new partnership arrangements are emerging, such as the relationship between the commissioner and the Prime Provider. Geographical boundaries and footprints for joint working are also changing including within the B&NES/Swindon/ Wiltshire Sustainability and Transformation Plan (STP) and scope of West of England Devolution as it develops.

At its simplest level commissioning is described as the process of planning, agreeing, purchasing and monitoring services. There are a range of commissioning functions carried out by the Council and CCG, illustrated by the commissioning cycle, below:



Staff engaged in commissioning activities are not confined to those with "commissioning" or "commissioner" in their job title. The workforce encompasses a wide range of professionals, experts and teams who support commissioning functions and activities.

Some commissioning activity is undertaken on a co-commissioned basis, working collaboratively and/ or in partnership with other Commissioners (or providers) but where responsibility is shared. There are some examples where this is currently taking place:

- Primary Care – Co-commissioned in by the CCG in conjunction with NHS England
- Co-commissioning by the Council with schools/academies or other Councils

The development of our co-commissioning arrangements with the Prime Provider is, necessarily, in its early stages. Our priority is to ensure the safe transfer of services to Virgin Care on 1 April 2017.

In this context, it is the intention that no significant changes will be made to current commissioning arrangements from April 2017. Current commissioning resources will be aligned to the new Prime Provider contract and the Dynamic Purchasing System arrangements.

A detailed description of commissioner roles and responsibilities is set out in Schedule 5C of the Prime Provider contract. As Prime Provider, Virgin Care will be responsible

for ensuring that the requirements of the contract flow down into the subcontracts and the specified requirements set in the Dynamic Purchasing System. Working in partnership with commissioners at the CCG and Council; Virgin Care will undertake contract negotiations with subcontractors comprising of legal, financial, operational and professional expertise.

The speed at which co-commissioning arrangements are developed and the commissioner delegates some functions and responsibilities to the Prime Provider must be balanced against our assurance that the arrangements are appropriate and robust. Also, against our assurance and confidence in the Prime Provider's state of readiness to take over some of these functions as ultimately the Council and CCG remain accountable for meeting the relevant statutory responsibilities and achievement of the high level outcomes and priorities for our population.

Over the next two to three years as part of the transformational change programme the CCG and the Council will begin a programme to implement further integration of our commissioning arrangements and structures along with the development of robust co-commissioning arrangements with Virgin Care, ensuring efficient alignment of resources to the functions/activities. Any proposals will be subject to engagement and consultation with staff and an organisational development plan that ensures that commissioning staff:

- Have the necessary skills and competencies;
- Feel confident and capable of dealing effectively with new approaches and challenges;
- Are supported, empowered and feel valued;
- Can span delivery and commissioning structures and who have support and the resources and systems to do so; and
- Can maximise the use of contract levers to support delivery in a Prime Provider model.

7 Managing Change

7.1 Service Users

Virgin Care will adhere to a set of robust, repeatable processes that support service transitions, with a clear focus on safe and secure transfer of service user care and support. Individuals, carers and families are at the heart of service design, with integrated IT systems providing seamless access to and sharing of high quality information across pathways.

To ensure a seamless transfer of service, Virgin Care's comprehensive mobilisation and communication plan will be developed as part of the contract to ensure GPs, staff, service users, carers and other stakeholders have a clear understanding of how to refer into the service during this transition period. The communications plan will be designed to ensure that people receive appropriately timed information about how services are transforming.

A dedicated point of contact will be provided for service users and their carers to contact the mobilisation team so that they can be provided with information about how the transition is being managed and how continuity of service will be maintained and how the service will evolve under Virgin Care.

Impact Assessment

Care Quality Commission guidelines recommend that the CCG and the Council should carry out equality impact assessments as part of best practice in health and care provision. In addition there are legal requirements which place a duty on public services to promote equality in its policy making, service delivery, enforcement and employment. This includes three interdependent areas of responsibility:

- To eliminate discrimination
- To promote equality of opportunity
- To promote good community relations

The Equality Impact Assessment covers the following areas:

- Age
- Disability
- Gender
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sexual Orientation

As part of the development of this Full Business Case, we have conducted a stage 1 Impact Assessment informed by our extensive stakeholder engagement. A copy of the assessment can be found in Appendix 2. The CCG and the Council have concluded that the proposed transition will not negatively impact any of the protected Equality

groups. The aim is to have a positive impact upon the provision of health and care services which will also benefit carers and families.

Following the appraisal of the Full Business Case and its approval, we will endeavour to complete a Stage 2 Full Impact Assessment that will assess in detail the expected impact upon equality groups, the key risks to groups in the event of non-partial or delayed delivery and an action plan to address any newly identified challenges.

7.2 Workforce

One of the key roles of a prime provider is to deliver transformational change that will reduce duplication and inefficiencies across the system. Virgin Care's national scale allows them to make best use of technology and organisational infrastructure to support service delivery and free up more resources for direct care and support.

Ensuring a smooth transfer of staff eligible for TUPE is crucial for health and social care services in B&NES. Central to this will be open and honest communication with all stakeholders including staff representatives, the CCG and the Council.

During mobilisation, Virgin Care will ensure that all staff feel confident that their future lies with the new service, that they have a much-valued role in the new service and that they will continue to receive their pension and NHS, Council or existing terms and conditions. Virgin Care will engage with staff representatives, providing newsletter updates and a dedicated contact email. Once staff have safely, transferred, Virgin Care will run a series of engagement workshops, explaining the service vision and sharing the roadmap for service transformation.

Staff engagement will be continuous, open, informed and positive. Staff will play a vital role in changing and innovating service delivery and Virgin Care will encourage this through multiple channels. The approach to engaging with staff representatives to ensure an orderly and effective transition and includes:

- Initial meetings to introduce Virgin Care and to discuss any questions and concerns, particularly those regarding TUPE and continuation of current pensions and other terms and conditions.
- Membership of the HR Project Management Group is offered and meeting notes and plans are shared for dissemination to staff more broadly
- Involvement in the induction planning group, policy group and staff survey development group.
- Keeping representatives and staff informed of all decisions, changes and issues that will affect the workforce.

Clear and regular communication with staff will ensure that people feel engaged and involved in their service; Virgin will use a variety of methods to do this, including:

- A weekly in-house newsletter to inform staff about current activity in the business and motivate them through positive messages and celebration of successes.

- Executive Team ‘back to the floor’ visits, where Executives make visits to services and shadow staff members, as well as meeting teams and listening to concerns.
- Personal Development Plans are drawn up with each member of staff and provide a means for the staff member and their manager to review progress and to undertake individual objective setting.
- Virgin’s Annual staff awards event provides a means by which they recognise the dedication and outstanding work of staff.
- The presentation of these awards forms a part of Virgin Care’s annual Big Thanks staff event. As well as the social aspect of this annual event, there are presentations about the direction of the business, celebrations of achievements and case studies of different projects.

Pensions and Pension Fund Position

a) NHS Pension Fund
Virgin have accepted the terms stated in the draft contract to allow continued enrolment in the NHS Pension fund for staff transferring from incumbent providers.

b) Council Pension Fund
The LGPS Avon Pension Fund is carrying out a fund valuation which will identify the surplus/liabilities on the fund at 31 March 2017.

Detailed work will be required to assess the impact on the incumbent provider, Virgin Care and the Council as fund guarantor. Scenarios that will need to be considered with arrangements in place to allow transfer of the following:

- Availability of the LGPS to staff who joined the pension scheme during Council employment

- Availability of the LGPS to staff who joined the pension scheme during Sirona employment

This work will need to consider the principles set out in the Department for Communities and Local Government’s ‘Fair Deal’ proposals

c) Other pension schemes
Where employees have joined other pension schemes transferring staff will be entitled to access a like for like scheme through the Virgin care Aviva scheme.

7.3 Estates and Equipment

The Environment Team within Virgin Care is the specialised resource for the transfer and management of property, equipment and facilities, health and safety, fire safety and security. Virgin Care are fully conversant with the requirements of CQC Care Quality Outcome 10 Safety and Suitability of Premises, and legislation such as the Health and Safety at Work Act 1974 (as amended), Regulatory Reform Fire Safety (Order) 2005, Approved Codes of Practice and NHS Health Building Notes and Technical Memoranda (this is not intended as an exhaustive list.)

When mobilising the contract Virgin Care will carry out a risk assessment of the type of premises concerned. This will take into account:

- The type of activity to be carried out
- The age and condition of the premises
- The frequency of use
- Responsibility for maintenance and repair

Virgin Care will conduct due diligence on all premises considered for use to ensure they are fit for purpose in the delivery of care. The due diligence regime adopted is tailored to take into account the outcome of the risk assessment carried out. This is so Virgin Care can match the level of investigation to the level of risk that the premises present. In this way Virgin Care are able to ensure that they can discharge their statutory responsibilities.

Virgin Care carries out an initial due diligence exercise as part of the mobilisation process. This exercise includes:

- A site survey to review if the site is fit for purpose, to identify functional suitability and to see what equipment is located at each site against asset list
- A data gathering exercise to identify current compliance levels
- A health and safety audit of current equipment and operational procedures
- A discussion with the landlord to identify likely occupation basis and maintenance responsibilities

The due diligence process includes:

- A desk top survey and site visit(s) carried out by the Environment Manager
- On site audits by technical specialists (extent dependent on outcome of desktop survey)
- A mapping of existing structure and processes used for the reporting of building management and health and safety issues

During the due diligence process Virgin Care will collect the certification necessary to demonstrate statutory compliance and establish if the premises are fit for purpose and safe to use. Virgin Care will work with landlords to mitigate risks and establish the actions necessary to achieve compliance if there are gaps. Negotiations with the landlords during the mobilisation process will help to establish:

- The base from which to migrate over to Virgin Care operational processes and procedures
- Who will provide hard and soft facilities management services
- Whether Virgin Care need to provide any facilities management services
- Where gaps in compliance are identified, Virgin Care will work closely with the landlords to plan a course of action in order not to delay safe transfer of the service.

Necessary works will be undertaken once the due diligence process is complete and service mobilisation has commenced. The service will then go through a strict internal sign off process culminating in completion of a statement of readiness to ‘go live’.

Lease sign off will follow this process. During mobilisation, Virgin Care will appoint a service manager who will manage all reporting relationships. Their duties in relation to premises will include (but are not limited to);

- Raising and managing requests for reactive maintenance
  Agreeing schedules of access for planned preventative maintenance (ensuring that service disruption is minimised)
- Managing arrangements for securing the building
- Monitoring performance standards against agreed key performance indicators
- Managing elements of statutory compliance such as Fire Safety which includes arranging fire alarm tests and evacuation drills
- Ensuring all relevant Facilities Management, cleaning and maintenance contracts are in place.
- Implementing and localising health and safety policies which are provided by the Environment Team
- Ensuring staff are appropriately trained
- Ensuring that clinical waste consignment notes are received.

NHS Properties

NHS Property Services Ltd (NHSPS) own or lease six core properties in B&NES that are utilised for the provision of community services:

a) Bath NHS House
b) Riverside, Bath
c) St Martin's Hospital, Bath
d) Paulton Hospital
e) Keynsham Health Centre
f) Chew Stoke Health Centre

Much of this space is currently occupied by Sirona for the delivery of community services. Some of the space is also occupied as offices and for other ancillary uses. Some is also let to other occupiers including the CCG.

The current nationally mandated arrangements with NHSPS mean that the CCG is generally liable for any vacant space costs (i.e. rent, service charge and facilities management costs) within their estate. It is however possible to release vacant space and the associated costs where whole buildings/sites (or substantial parts of buildings/sites) can be made available for disposal. It is therefore vital that NHSPS and the CCG work together with existing and potential occupiers to identify where there is an ongoing requirement for the existing estate and where there are opportunities to rationalise the estate and reduce costs.

Preliminary discussions with Sirona suggest that they are likely to substantially reduce their footprint across the NHSPS owned and leased estate. Further detailed discussions are required to understand where they wish to remain in occupation.

Virgin Care representatives have now visited the NHSPS properties, but their detailed property requirements will depend on the staff that will transfer to them from incumbent providers and the space that Sirona will wish to continue to occupy.

Although they have indicated that they will aim for a period of stability during the first three months of the contract, they have also confirmed their desire to identify opportunities for property cost savings.

Moving forward, it is anticipated that work will need to focus on the office space within the NHSPS estate where there is the greatest risk of vacant space being created as a result of the change in provider. However, the changes may provide opportunities to release cost through the disposal of surplus property.

a) Bath NHS House
This property is leasehold and is principally used as office type accommodation by Sirona and AWP. Virgin Care currently occupies part of the ground floor of this property as part of their contract to provide services in the Wiltshire CCG area and they have indicated their desire to vacate the property. Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) hold the head lease on this property and NHSPS holds a sub-lease of part of the property. There is an opportunity to break the lease in November 2016. It is therefore vital that both Sirona and Virgin's requirements in respect of this property are urgently understood.
b) Riverside, Bath
This property is leasehold. The ground floor is available for use as clinical space and proposals have been developed to use it as a focus for sexual health services. The first floor is principally used as office accommodation (with some dental services). It is multi occupied by Sirona, AWP and BEMS+. It is important that the use of this property is maximised and work is required to understand the ongoing requirements for the ground floor clinical space and first floor offices.
c) St Martin's Hospital, Bath
This is a multi-occupied freehold site. The majority of the modern ward and outpatient block is occupied by Sirona, with AWP occupying one wing. It is anticipated that Virgin will take over Sirona's occupation of the modern ward block. The historic buildings on the site include a significant amount of office space that is occupied by Sirona and other organisations including the CCG, NHSPS and the Council. In the event that Sirona no longer require a substantial presence within this part of the site, there is a risk that a significant amount of space will become available/vacant. NHSPS will therefore work with all occupiers to examine opportunities to rationalise the use of these historic buildings. The buildings are not ideally suited for providing efficient, modern, office accommodation and work will therefore be required to consider whether the remaining occupiers could be relocated to other office accommodation in the area to mitigate the risk of the vacant space costs falling on the CCG.
d) Paulton Hospital
This is a multi-occupied freehold site with AWP, SWASFT, BDUC and the RUH all occupying parts of the site alongside Sirona who run the inpatient beds, outpatient services and the minor injuries unit.

It is anticipated that Virgin Care will take over Sirona's occupation of this property.

The GP practices in the area have indicated a desire to better use this facility to deliver services and discussions will be progressed with them once Virgin Care's property requirements for this site have been understood.

e) Keynsham Health Centre

This is a multi-occupied freehold site. Whilst one wing is occupied by a GP practice, a significant proportion of the property is occupied by Sirona as outpatient clinics and as offices.

Discussions will be required with Sirona and Virgin Care to understand their requirements in respect of this property. There is a risk that neither provider will require the second floor offices.

f) Chew Stoke Health Centre

This is a leasehold property that is currently used principally as an office base for staff working in the community.

At this stage, it is assumed that there will be an ongoing requirement for this property by Virgin Care and that they will take over Sirona's occupation.

Leases will be granted on full repairing terms at market rents for these buildings. The current occupation agreements will expire end March 2017 and thereafter each of the locations will be available for Virgin Care based on the heads of terms offered in the original tender documents.

Council Properties

The premises owned by B&NES currently occupied by incumbent providers and offered to Virgin Care mainly operate on a desk licence arrangement. Desk Licences are essentially an agreement to permit use of the workstation and the IT at an all-in fee per desk. The Council will provide all facilities, excluding computer hardware and broadband, that are satisfactory and suitable for the licensee's permitted use. Properties include:

a) Children's Centres

Desk licences are available across multiple Children's Centres including;

- Parkside CC
- Radstock CC
- Keynsham CC
- Weston CC
- St Martins CC

b) The Hollies

This is an office and community building operated by B&NES

c) Radstock Road Depot
This is warehouse and office space, with self-contained ground floor warehouse and staff facilities space forming part of a council depot site used as a community equipment store.
d) Connections Day Centre, Frome Rd, Radstock
This is a single storey building used as a day centre with catering and common room facilities.

Virgin Care Estates representatives have started a programme of inspections which will determine which final sites they will need to occupy. In the event that there are premises they do not need, B&NES will retain these and deal with them as for any other surplus property.

Facilities Management (FM) Services

Sirona currently provide some FM services to the existing NHSPS estate and to other occupiers of that property. It is unlikely that Sirona will wish to continue the provision of FM in properties that they do not occupy.

Virgin Care's preference is not to take on FM services and to enter into contracts with other providers for those services.

There may be TUPE implications for Sirona staff currently providing FM services and there are also FM service continuity issues that need to be resolved during contract due diligence.

7.4 IT Infrastructure

Virgin Care will follow a set of clear, robust, tested and repeatable processes utilised on take-over of new services that ensures safe and secure migration of both clinical and corporate data from the incumbent providers to Virgin Care. Virgin Care's safe transfer protocol emphasises minimal change in the first 100 days of taking on a new service. The implication of this approach is to minimise the number of clinical and corporate information system changes at contract 'go live'.

Where IT systems or processes do change on 1st April it is recognised that some disruption will occur. The Virgin Care transition plan will identify these areas in advance and make available additional resource to support staff through the change.

The main clinical system in use by services within the scope of the prime provider contract is SystmOne provided by TPP and contracted by Sirona. The contract with TPP expires on 31 March 2017 and discussions have commenced between Virgin Care, Sirona, the CCG and the Council to identify an agreed route for the transfer of clinical records.

Virgin Care has stated a preference for a route that avoids a data migration. Should a data migration route be required each clinical system provider is responsible for

resourcing the data migration process for their system. Virgin Care will support this by assigning each project a clinical and an information governance lead to ensure that clinical and business risk assessments are undertaken prior to any data transfer and the testing process is closely monitored.

Migration plans for historical data differ between system providers, but the data migration will follow common procedures which have been included into the specifications and project plan(s), our intended outcome being the continued access for staff to the appropriate information required to support ongoing care.

The Local Authority case management system in use for adults and children social care is Liquid Logic, a relatively recent implementation. Virgin Care staff will initially use the Liquid Logic application in much the same way that staff in the in-scope services use the application currently.

In addition to SystmOne and Liquid Logic there are a significant number of additional IT systems and software used by staff working in the in-scope services. These range from commercially available software such as e-mail to in-house systems owned by Sirona. The use of these IT systems will be picked up in discussions between Sirona and Virgin Care to identify the processes reliant upon these systems and ensure that systems are in place to maintain them from 1 April 2017.

Usage of IT systems that need to be understood ahead of 1st April is not limited to those within Sirona and similar conversations will need to take place between Virgin Care and other providers to ensure a safe transfer. The RUH for example provide clinical systems for some in scope services.

Virgin Care will work jointly with the CCG and the Council to understand the needs of the population, considering how to turn local data into meaningful and actionable intelligence. They will be proactive with new uses of data including development of risk stratification models and applied data science techniques where relevant.

Virgin Care will operate within a collaborative research partnership environment, involving local academic and community stakeholders. All analytical activities will be undertaken within a structured ethical framework. Virgin Care will commit to being open with data and methodologies wherever legal and practical.

Delivery of truly integrated care will require IT improvements within and between organisations; specifically, the ability to share information more effectively. This will be achieved by:

- Using a single platform to share and exchange patient record information and to hold integrated care plans (though all provider organisations will continue to maintain their own versions on their own systems)
- Granting of access rights and revision of information sharing agreements such that relevant staff from all partner organisations will have access to and (in some cases) the ability to amend records
- Joint working and co-operation across all Providers including GPs, RUH, AWP, Dorothy House and Sirona is required to put in place this joined up record. Commissioners will work with Virgin care to help facilitate this.

- Post contract award, detailed work will commence to better understand the infrastructure requirements in the locality needed to support safe transition and the realisation of the integrated record.
- The Council has offered to support this process by making some of its infrastructure available to staff delivering community services if needed.
- In terms of Virgin Cares infrastructure arrangements and proposals, whilst more detailed due diligence is necessary, their proposals for sharing, storing and sharing records and information have not highlighted any technical concerns that appear insurmountable.

The CCG contracts with South Central & West CSU for the majority of its IT infrastructure. The CSU in turn has an SLA with Sirona for delivery of some IT services at Kempthorne House, the most significant element of which is telephony. The CSU has been briefed of the your care, your way procurement and is aware of the need to ensure a safe transition of its sub contracted services.

7.5 Working with delivery partners

The main role of a prime provider is to drive greater partnership and collaboration across the system, bringing together the strengths of local people, communities and organisations to deliver a more holistic and personalised service.

Virgin Care is already building strong relationships with a wide range of local voluntary sector organisations as well as key partners such as GP practices and the RUH. The range of services within the scope of the prime provider contract provides extensive opportunities for local organisations to work in partnership with Virgin Care to deliver improved outcomes for the population.

GP practices will be at the heart of the new model, with multidisciplinary teams wrapped around GP hubs in the community to bring together expertise and insight. These teams will enable health and social care practitioners, including hospital consultants, social workers, mental health professionals and local voluntary sector organisations to come together so that all the key players in our local health and care system are working in partnership.

The RUH will be working closely with Virgin Care in a number of areas. A key focus will be reducing the number of preventable hospital admissions and improving the discharge process so that people have the right support in the community to avoid a trip to hospital and return home safely as soon as possible should they need hospital care.

The RUH have also stated their intention to deliver more of their services outside hospital, supporting their specialists to deliver clinics in community settings and working more closely with GPs through multidisciplinary meetings. This work is already happening in areas such as diabetes care and dermatology and we expect Virgin Care to support the RUH to extend this further.

Virgin Care will also become a key partner within the B&NES, Swindon and Wiltshire Sustainability and Transformation Plan (STP) footprint. Working together with the

CCGs, Councils, hospitals and other community providers across the three areas, Virgin Care will have an important role to play in delivering the STP's objectives.

7.6 Managing risk

There are a number of key risks to the implementation of the new model of care in the proposed timescales, which are identified alongside the risk mitigation in Table 3 below.

Table 3: Key Risks

Ref	Risk	Mitigation
1	**Funding** There is a risk that on service transition there are emerging provider costs that are not funded from the existing contract financial envelope.	Assurance of Virgin Care's ability to operate within the agreed financial envelope and commissioner adequately specifying services and activity levels.
2	**Service Mobilisation and Continuity** There is a risk that it is not possible to mobilise the services within the proposed timescales to allow for safe transfer by April 2017.	Develop and implement detailed mobilisation plan outlining key milestones and using a detailed risk and mitigation log. Establish the Safe Transfer Group and Mobilisation Workstreams to govern the mobilisation process. Early identification of contract critical due diligence.
3	**Winter Pressures** There is a risk that it is not possible to provide continuity of service as a result of emerging winter pressures during mobilisation.	Risk assessments to be carried out for each service to understand any capacity/staffing issues. Appropriate risk-mitigation plans to be put in place on a case-by-case basis.
4	**Staff Transfer** The transition represents organisational change challenges for employees of both incumbent providers as well as the CCG and Council.	A detailed organisational development and change management action plan is in place to enable the workforce to be supported through the period of organisational change and the introduction of new ways of working.
5	**Recruitment** It is not possible to recruit to new roles required to deliver the new model of care within the current proposed timescales and as such it is not possible to implement within the timescales.	Early gap analysis to understand where additional skills and/or capacity are required. Early commencement of recruitment processes within mobilisation phase.

Ref	Risk	Mitigation
6	**Requirement for financial balance in year impacts upon delivery** Delays in implementation or benefits realisation will result in unplanned costs which will need to be met through reduction in planned investment. This could cause further delay in benefits realisation over the period.	Establish process through ***your care, your way*** steering group to progress transition in prioritised order and establish robust monitoring arrangements.
7	**Benefits Realisation** The implemented services do not deliver the expected impact on people's care experience and people's health.	Timely and ongoing evaluation of service delivery so that services can be adjusted if necessary.
8	**Stakeholder buy-in** Involvement is lacking during the mobilisation phase, causing delays to implementation and as a result the proposed benefits cannot be realised within timeframes.	Ensure all stakeholders are actively engaged with mobilisation, with sufficient opportunities for stakeholders to input and feedback. Communicate progress regularly to all relevant stakeholders, high level and tailored to their role,
9	**Culture Change** The level of culture change required for all stakeholders to operate in a truly integrated way within the timescales is challenging.	Timely and continuous engagement with key stakeholders and staff to foster understanding of the new model of care.
10	**Information Sharing** The current IT landscape across the whole of the health and care economy (system wide IT structures and information governance) is not yet sufficiently established to enable a single care record and care planning across provider or a joined-up approach	Successful mobilisation is predicated on stakeholders agreeing to share data and engage with Virgin Care in the use of Lumira. The CCG and the Council will need to facilitate collaboration and cooperation and wherever possible make provisions within existing and future contracts to mandate the requirement to work with Virgin Care (and indeed any party the CCG and the Council wish to share data with in support of achieving enhanced outcomes, subject to appropriate information governance arrangements),

Ref	Risk	Mitigation
11	**Information Sharing Cost** It is the expectation that the data provider (i.e. Council, RUH, GPs etc.) will bear the cost of integrating with Lumira which may result in a barrier to those organisations.	The CCG and the Council have a responsibility to put collective pressure on vendors to agree pricing and should consider splitting the cost of any system customisation that needs to be done. Virgin Care have committed to some financial support for this, however this would need to be looked at on a case by case basis.
12	**Clinical Systems** The safe transfer of services is built around having continued access to the existing clinical systems. Any reduced access to systems at go live due to technical or contractual issues is a risk to safe transfer of services	Virgin Care has commenced work with incumbents to identify existing contracts with clinical suppliers and potential to novate contracts.

8 Delivering value for money

8.1 Commissioning Joint Funding Model

Background

To support the financial management, reporting and oversight of the contract a robust financial operating model is required. This will allow both the Council and CCG to transfer funding to the Prime Provider, meet reporting requirements and allow oversight to assess value for money.

Financial Model Key Themes

To give both the Council and CCG assurance in the development of a Commissioning Joint Funding Model the following key criteria will need to be met though the recommended model:

- **Support strategic commissioning model**

  The Commissioning Joint Funding Model will need to align to the target operating model for strategic commissioning supporting the Council and the CCG. This will need to allow flexibility to consider organisational changes through further Council and CCG integration and the development of the B&NES, Swindon, Wiltshire Sustainability and Transformation Plan. This builds on the principles of integration that have been set through the B&NES Better Care Fund plan.

- **Maximise functional benefits to the system**

  The Commissioning Joint Funding Model will need to support the principles of appropriate, economic, efficient and effective use of public funding to ensure that funds are made available to deliver services that meet both Council and CCG strategic priorities.

- **Avoid duplication**

  The Commissioning Joint Funding Model will need to support joint management of the Prime Provider contract including a Lead Commissioner supporting the contract review, performance reporting and finance support to ensure a consistent approach to managing the contract and relationships. The outputs will need to satisfy both organisations internal and external reporting requirements.

- **Maximise tax efficiency**

  The Commissioning Joint Funding Model must support effective and compliant application of tax accounting policies to ensure that both organisations are not exposed to VAT inefficiencies.

- **Maximise flexibility to direct funds**

  The Commissioning Joint Funding Model should give the commissioner flexibility to incentivise cash-releasing service developments and to re-direct released funds to priority areas of need. This will need to be supported by appropriate risk and gain share arrangements.

- **Allow direct control and intervention from accountable organisations**

  The Commissioning Joint Funding Model will need to have financial governance arrangements in place that allow for direct lines of intervention for both the Council and CCG's accountable officers.

- **Allow discharge of statutory duties**

  The Commissioning Joint Funding Model will need to allow for the delegation of statutory duties to the Lead Commissioner

- **Accounting compliance**

  The financial model will need to ensure full compliance with the following financial reporting standards along with each organisations own financial accounting requirements:

  - IFRS 11 Joint arrangements http://www.iasplus.com/en/standards/ifrs/ifrs11
  - IFRS 10 Consolidated financial statements http://www.iasplus.com/en/standards/ifrs/ifrs10
  - IAS 18 Revenue http://www.iasplus.com/en/standards/ias/ias18

The proposed finance model and supporting documentation will need to ensure that these accounting standards are followed; this will help define the level of control across both commissioning organisations. Direct line of control is summarised across the arrangements in the table below

Arrangement	Each body	One body
Aligned budget	✓	
Pooled budget	✓	
Joint commissioning	✓	
Collaborative commissioning	✓	
Delegated commissioning		✓
Lead commissioning		✓

The proposed model

The proposed model is a Pooled Budget hosted by the Council as lead commissioner acting on behalf of the CCG and Council under joint working arrangements

The mechanism for entering into the pooled budget will be under Section 75 of the NHS Act 2006, under the Act the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised.

Entering into a pooled budget with the Council as the lead commissioner will form part of the 2017/18 Better Care Fund Plan and build on the successful joint commissioning relationships in B&NES including pooled budgets for Learning Disabilities and Mental Health. This will allow each funding body to retain control with the Council having lead commissioner responsibilities under joint working for both organisations.

This recommendation will allow the both the Council and CCG to achieve:

Pooled Budgets fit the delivery of **strategic commissioning** and support the Government's mandate to NHS England for 2016-17 which states NHS England should support the NHS to achieve the Government's aim that health and social care are integrated across the country by 2020, including through the Better Care Fund.

This will allow **functional benefits** to be maximised through joint investment into services that will provide both Social Care and Health benefits to the B&NES population.

A single approach to commissioning, contract management and performance will **avoid duplication** of effort for both Providers and Commissioners allowing the principles of joint management and reporting to be fully embedded.

Through building on the existing Section 75 agreement that governs the Better Care Fund the Council and CCG will be able to satisfy their ability to **discharge duties** whilst maintaining **direct control** through the supporting partnership governance arrangements.

This approach will allow the maximisation of **tax efficiencies** whilst maintaining full compliance through following the accounting standards that apply to pooled budgets and joint reporting. This will give the opportunity to work collaboratively **and direct funds** to priority areas of service provision for both organisations.

Contract management and support services

The contract payment mechanism chosen will need to be aligned to the proposed Commissioning Joint Funding Model including commissioning, contract and performance management. Payment mechanisms have been identified in section 8.4 below.

Support services including finance will need to ensure that the needs of both organisations can be met, this will need to include:

- Reporting requirements – ensure content, format and frequency meets the reporting needs of both organisations
- Legislation – ensure that treatment of activity and financial information follows that guidance that applies to both organisations to ensure the compliance

This option has the following benefits:

- Supports the integration agenda at a commissioner level
- Build on the principles of the BCF for pooling budgets
- Builds on the existing pooled budget relationship that benefits from the Council finance infrastructure and systems including case management and reporting through the Liquidlogic Care and Health system
- New service proposals that require charging mechanisms will benefit from existing systems that allow payment and income recovery through Council systems
- Contract management already in place from high volume of current community service providers that are Council commissioned

Risk associated with this proposal:

- The CCG will need assurance that there is the correct governance in place to support management and decision making, this will be stipulated through the section 75 agreement
- Resources will need to be correctly aligned across both organisations to support the Lead Commissioner with contract management, commissioning and reporting
- There needs to be assurance that reporting requirements can be fulfilled and in the correct format to meet all externally mandated (NHSE) requirements for the CCG.

In the event that funding contributions and supporting risk share arrangements have not been fully defined and agreed by 1 April 2017, the Council and CCG will retain their current financial operating procedures for paying community health and care contracts.

Commissioner Risk Sharing

Risk Sharing

The Commissioning Joint Funding Model will need to be underpinned by a risk sharing agreement that allows flexibility within the financial envelope, but also gives both organisations assurance that they will not be exposed to any undue financial risk.

The detailed risk share will need to be developed following the progression of the agreed Commissioning Joint Funding Model. However it is recommended that the following risk share principles are applied:

- Funding contributions will need to be aligned to both Council and CCG financial plans; these will be subject to change through the budget setting process for both organisations.

- Treatment of financial risk will need to be linked to the treatment of over / underspends through the prime provider contract.

- Both organisations governance requirements will need to be met when agreeing investments or savings that will apply to the pooled budget.

Treatment of Investment

- Council and CCG Commissioner funding percentages will be proportionate to the value of original baseline funding provided for joint funded demand driven services.

- Where the provision of services has a direct relationship to a commissioning organisation the funding request is managed through a direct relationship between the commissioner and the prime provider.

Treatment for savings

- Where the provision of services are joint funded and have shared financial risks and benefits, savings above financial plan requirements are recognised by the pool for reinvestment; release of benefit / funding contribution is in line with the original funding proportions.

- Where the provision of services have a direct relationship to a commissioning organisation and a service review leads to a saving over and above financial plan requirements the benefit will be considered for re-investment into the pooled services.

8.1 The funding envelope

Commissioner Contract Funding

The funding envelope for in-scope all community service contracts is c£70.5m across all current providers. The table below shows the specific funding for the services delivered and sub-contracted by the Prime Provider contract alongside services remaining under Council and CCG Commissioning arrangements from 1 April 2017.

This is subject to change through the preferred bidder and during the contract award phase of the procurement

Prime Provider Funding Envelope	Baseline 2016/17 Year 0 £000
Services Delivered by Prime Provider	
Council Commissioned Services Delivered by Prime Provider	16,288
CCG Commissioned Services Delivered by Prime Provider	22,052
CQUIN*	551
Sub Total (excl. CQUIN)	**38,340**
Services Subcontracted by Prime Provider	
Council Commissioned Services Sub-Contracted by Prime Provider	12,684
CCG Commissioned Services Sub-Contracted by Prime Provider	897
CQUIN*	22
Sub total	**13,581**
Total Prime Funding (excl. CQUIN)	**51,921**
Council Commissioned Services	10,754
CCG Commissioned Services	7,859
Total In-Scope Funding	**70,534**

**Commissioning for Quality and Innovation (CQUIN) values are held outside of the contract envelope and will be paid in accordance with the NHS England planning guidance.*

The funding envelope for the Prime contract is made up of the 2016/17 Commissioner baseline funding levels held in Council and CCG budgets. The funding for the contract from 2017/18 will be fully aligned to contract sums that are agreed on Full Business Case sign off and contract award

The table below shows the percentage share of the funding across commissioning organisations.

Commissioner	Percentage share of funding	Funding contribution £000
Bath & North East Somerset Council	56.32%	39,726
Bath and North East Somerset Clinical Commissioning Group	43.68%	30,808
Total	**100.00%**	**70,534**

Contract Funding Principles

The following funding assumptions were set out in the 'your care, your way' Outline Business Case and will continue to apply to the financial model and future contracting arrangements.

- The funding envelope may need to be adjusted from the 2016/17 baseline to align with the Council and CCG planning assumptions in health and care funding arising from both organisations' financial planning and annual budget-setting processes.

- Identified areas for cash-releasing efficiency savings or improving value will need to align to new commissioning and provider delivery models.

- Demographic change pressures will need to be managed within available resources.

- New investment requests will be reviewed on an individual basis and require sound quantitative and qualitative evidence of system benefits.

- Commissioners and providers will continue to work in partnership to jointly identify areas of opportunity including back office efficiencies.

In addition and taking into account the financial challenge that both the Council and CCG face the following contract principles will apply to the Prime Provider contract:

- On contract award the future operating costs for delivering the Prime Provider contract and sub-contracted services will need to be met from within the baseline funding envelope.

- For 2017/18 this will incorporate existing planning assumptions for savings and growth.

- The re-alignment of funding required for revisions to service operating costs will be subject to Commissioner and Prime Provider agreement; this will provide opening contract sums for services delivered by the Prime.

- Any future revisions to contract funding will be required to follow the contract monitoring and governance arrangements set out in section 5.5.

- Commissioner and Provider funding requests will need to be supported with evidence based rationale.

- Any future funding decisions to meet cost pressures will need to follow the requirements of the Councils approved Budget Management Scheme and the CCG's financial planning and approvals process.

Service Planning, Efficiencies and Transformation

Both the Council and CCG are developing their future year financial plans. In order to maintain high quality service provision against a backdrop of reducing government funding the plans need to identify areas that can improve financial efficiency to help meet demand and improve service delivery.

Areas of focus for both the Council and CCG are

- Value for Money – ensuring our approach to commissioning and contract management can demonstrate that services are performing well and are price efficient

- Practice Development – continually review and improve services to identify opportunities across health and care e.g. commissioning approach, service offering, reviews, support planning

- Provider Relationship – improving our systems and contracting methods to support a streamlined, well controlled and transparent approach in partnership with our providers.

The role of the Prime Provider is to work in partnership with the Council and CCG as a key delivery partner working alongside Commissioners on the development and implementation of cost improvement opportunities.

Open Book Accounting

The monitoring and management of the Prime Provider contract will be supported by an agreed set of finance dashboards that sit alongside a suite of reports to support the contract management and review process.

From the Commissioning perspective the format and frequency will need to cover

- Quarterly full contract finance dashboard for services delivered and sub-contracted by the Prime Provider
- Service level monitoring to support the lead commissioner at a portfolio level
- Service line actual expenditure against budget, year to date and forecast expenditure
- Transparency over contract funding including capped funding towards corporate overheads

The format and detailed content will need to be agreed between commissioners and the Prime Provider before go-live, the reported information will need to consider the availability of information through the contract transition and mobilisation.

8.3 Prime Provider Contract Value

The Following funding assumptions have been built into the contract model

- Values from 2017/18 will need to incorporate the Council and CCG financial planning assumptions on approval of the Council budget and CCG financial plan.
- Pay and other running costs inflation is to be funded from internal efficiencies generated by the Prime Provider working on the basis of flat cash from commissioners
- Unavoidable future growth pressures as a result of legislative or policy changes will need to be considered and incorporated into the financial planning cycle.

Contract Value

The tables below show the contract values for services delivered by the Prime Provider, services that are subcontracted by the Prime and in-scope services that will be commissioned by the Council and CCG from the 1 April 2017.

Table 1 - Prime Provider Contract Schedule	2017/18 Year 1 £000	2018/19 Year 2 £000	2019/20 Year 3 £000	2020/21 Year 4 £000	2021/22 Year 5 £000	2022/23 Year 6 £000	2023/24 Year 7 £000	Total £000
Management & Support Services								
inc. Finance, IT, HR, Business Development	3,255	3,255	3,255	3,255	3,255	3,255	3,255	**22,786**
Operational Costs								
inc. Estates, Facilities, Transport, Running Costs	1,753	1,753	1,753	1,753	1,753	1,753	1,753	**12,269**
Total Overheads	**5,008**	**5,008**	**5,008**	**5,008**	**5,008**	**5,008**	**5,008**	**35,055**
Council Services Delivered by Prime Provider								
Regaining Health and Independence (Early Intervention and Targeted)	12,076	12,076	12,076	12,076	12,076	12,076	12,076	**84,535**
Living Well and Staying Well (Prevention and Self Management)	3,813	3,813	3,813	3,813	3,813	3,813	3,813	**26,690**
Sub Total	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**111,226**
Council Total	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**15,889**	**111,226**
CCG Services Delivered by Prime Provider								
Regaining Health and Independence (Early Intervention and Targeted)	10,485	10,485	10,485	10,485	10,485	10,485	10,485	**73,395**
Enhanced and Specialist Support	6,958	6,958	6,958	6,958	6,958	6,958	6,958	**48,703**
Sub total	**17,443**	**17,443**	**17,443**	**17,443**	**17,443**	**17,443**	**17,443**	**122,098**
CQUIN & Tariff assumptions required	506	506	506	506	506	506	506	**3,545**
Total Prime Contract (Excluding CQUIN)	**38,340**	**38,340**	**38,340**	**38,340**	**38,340**	**38,340**	**38,340**	**268,379**

Table 2 - Prime Provider Sub-Contract Schedule	2017/18 Year 1 £000	2018/19 Year 2 £000	2019/20 Year 3 £000	2020/21 Year 4 £000	2021/22 Year 5 £000	2022/23 Year 6 £000	2023/24 Year 7 £000	Total £000
Council Services Sub-Contracted by Prime Provider								
Regaining Health and Independence (Early Intervention and Targeted)	4,951	4,951	4,951	4,951	4,951	4,951	4,951	**34,656**
Living Well and Staying Well (Prevention and Self Management)	3,387	3,387	3,387	3,387	3,387	3,387	3,387	**23,707**
Enhanced and Specialist Support	4,347	4,347	4,347	4,347	4,347	4,347	4,347	**30,426**
Sub Total	**12,684**	**12,684**	**12,684**	**12,684**	**12,684**	**12,684**	**12,684**	**88,789**
CCG Services Sub-Contracted by Prime Provider								
Enhanced and Specialist Support	897	897	897	897	897	897	897	**6,277**
Sub total	**897**	**897**	**897**	**897**	**897**	**897**	**897**	**6,277**
Total Prime Sub-Contracts	**13,581**	**13,581**	**13,581**	**13,581**	**13,581**	**13,581**	**13,581**	**95,067**
Total Prime Contract (Excluding CQUIN)	**51,921**	**51,921**	**51,921**	**51,921**	**51,921**	**51,921**	**51,921**	**363,445**

Table 3 - Council and CCG Commissioned services from 1st April	2017/18 Year 1 £000	2018/19 Year 2 £000	2019/20 Year 3 £000	2020/21 Year 4 £000	2021/22 Year 5 £000	2022/23 Year 6 £000	2023/24 Year 7 £000	Total £000
Enhanced and Specialist Support	4,201	4,201	4,201	4,201	4,201	4,201	4,201	**29,408**
Regaining Health and Independence (Early Intervention and Targeted)	14,412	14,412	14,412	14,412	14,412	14,412	14,412	**100,883**
Total	**18,613**	**18,613**	**18,613**	**18,613**	**18,613**	**18,613**	**18,613**	**130,291**
Community Services In-Scope Total	**70,534**	**70,534**	**70,534**	**70,534**	**70,534**	**70,534**	**70,534**	**493,736**

Prime Provider Financial Risk and Benefits

To support the implementation and delivery of service improvements a key priority is to have a documented and jointly agreed mechanism that allows for system benefits to be identified, realised and re-invested where possible.

The Prime Provider will work collaboratively with commissioners to ensure that value for money is achieved and funding can be directed to priority areas of service provision.

The following principles will apply to contract financial risks and benefits

- The Prime Provider and commissioners will work together to identify and agree areas of opportunity that may create financial and non-financial efficiency.

- If savings are delivered above the planned levels these will be held in a risk pool and considered for re-investment ring fenced to invest in activities that meet the agreed outcomes of the Prime Provider contract.

- The Prime Provider will take on financial risk for areas where they have direct influence of the mechanisms required for mitigation allowing the flexibility to manage funding within the contract envelope.

- Activity and funding levels will be jointly reviewed and agreed to ensure that robust and relevant contract monitoring and performance measures can be put in place.

Investments and Savings

Virgin Care has a long history of enabling transformation across community delivered services. They have used this experience to forecast the key investment lines and amounts required to deliver this contract.

These investments can be summarised as:

- Infrastructure – IM&T hardware and software (subject to expected asset transfer), Care Coordination Centre and care navigation. This includes all supporting technologies such as the integrated records system (Lumira), DOS, CMS and supporting clinical systems plus support for virtual wards;

- People – development of new roles, workforce development and upskilling, development of the non-contracted workforce i.e. volunteers;

- Community support – VCSE innovation fund, early help and digital counselling;

- Transformation – service redesign expertise, pathway development, community service investment and mobilisation.

Virgin Care recognises that at this stage values and timing expressed for investments and savings are indicative with full work up into business cases required as part of Virgin Care due diligence. It is anticipated that these investments will be funded by Virgin Care and recovered from future year savings.

Prime Provider Health & Care System Risk & Gain

Purchased Care Transformation

Through delegated responsibility the Prime Provider will have the responsibility for carrying out the statutory Social Care function and Continuing Healthcare assessments; this includes care planning and the commitment of funding for packages of care.

To allow the Council and CCG to meet the cost of increasing demand a number of proposals are being taken forward to build on best practice approaches that have supported service delivery and delivered financial benefits.

The Prime Provider will be a delivery partner to help manage the service change required to support the financial planning objectives, this will be supported by a risk sharing agreement covering the following principles:

- Joint Commitment to implement the design and delivery of the savings opportunities approved through the financial planning process
- Commitment to support the achievement of financial planning targets held by the Council and CCG for Council and CCG retained purchased care budgets
- Create financial incentives that allow re-investment where in year savings above target are realised
- Where applicable manage the re-investment of in year benefits through the transfer of savings into a risk pool that is jointly governed by the Commissioner and Prime Provider

Non-elective reductions

Through the B&NES Better Care Fund plan there is a joint commitment to develop our community services care offer to help people meet their care needs in an independent community setting. This will help reduce the dependency on secondary care services though responsive community health and care that will reduce hospital non-elective admissions.

The Prime Provider has identified savings opportunities in reducing the current cost of hospital non-elective admissions. As the activity or intervention in one care setting will lead to an activity reduction and financial benefit in another care setting the following principles to risk and benefit sharing will apply:

- Partnership wide agreement will need to be in place to allow money to be re-directed when benefits are realised
- Mechanisms will need to be in place to monitor the benefits and activity reductions of care being delivered in alternative settings

- Approved system wide savings plans will need to release financial benefits back to the Commissioner to prevent spending the same pound twice

- When savings realised are above planned levels they will be held with partners for reinvestment

- Commissioners and providers will need to agree the process to allow the release of system wide savings for investments

8.4 Payment mechanisms

Payment Mechanism 2017/18 Contract

Once the financial operating model has been agreed the contract payment method will need to be finalised on the approval of the full business case and supporting contract.

This will cover the following for the Prime Provider payment:

- Core prime functions
- DPS contract payments
- CQUIN payments
- Performance based payment mechanisms

At this stage it is recommended that core prime functions are paid through a block contract supported by a commissioner and prime provider risk share agreement which sets out priority areas of service transformation, with operational and financial efficiency targets.

The frequency of the CCG to Council payment will be monthly into the pooled budget; this is in line with NHS planning guidance. This will not give rise to any material treasury implications for the Council as this will be a pass through payment to the Prime Provider.

For any demand driven services that are paid through a variable payment mechanism to the Prime Provider; the 2017/18 contract value and funding transfer will be subject to both Prime Provider and Commissioner reviewing and jointly agreeing anticipated activity levels and unity prices.

The DPS contract payments will be subject to the revised contract terms put in place between the prime provider and sub-contractor. Until these contract agreements are in place payments will be made under current terms by the commissioning organisation.

CQUIN payments will be made in line with NHS planning guidance and agreed by the commissioner and prime provider.

Any performance based payment mechanisms will be supported by contractual mechanisms between commissioner and prime subject to joint agreement of activity data, KPI’s and the financial quantum.

8.5 Taxation

Commissioner VAT Implications

Under the proposed financial operating model careful consideration will need to be given to compliance with VAT accounting requirements. The detailed VAT implications of pooled budgets are subject to ongoing discussion at the National CIPFA VAT committee where B&NES Council is well represented.

The treatment of VAT in the pooled budget proposal will not expose either organisation to any undue risk as both organisations will maintain joint control and apply net accounting for pooled budget contributions. This will result in each organisations financial statement reporting their contribution and expenditure separately.

For the CCG funded services HMRC has indicated that the NHS VAT accounting requirements will apply where the statutory obligation to provide the services lies within the CCG.

For Council funded services where VAT is applicable to purchases under its statutory obligation the VAT will be recoverable under Section 33, VAT Act 1994, this will not have a negative impact on the Council's partial exemption position.

Prime Provider Tax implications

Virgin Care is registered and incorporated in the UK and meets its UK tax obligations. A full financial assessment including legal compliance of tax arrangements has been completed and Virgin Care is fully compliant. This assessment has also provided assurance around Virgin Care's financial viability.

9 Recommendation

The governing bodies of the CCG and the Council are asked to consider the following three options. Option 3 is the recommended option.

Option 1: Do nothing

The CCG and the Council recognise that the creation of a prime provider for community services is a bold and transformational step. However, services cannot continue to be delivered in the same way because in the long term this is unaffordable, unsustainable and, most importantly, will not deliver the preventative, collaborative and personalised service that local people and professionals have asked for. Also a significant proportion of contracts will expire on 31 March 2017.

Option 2: Work with existing providers to deliver our priorities

There are many strengths in existing community services locally with strong examples of innovation and partnership working. These include services that have won awards and plaudits from patients, families, carers and communities. Despite this, the way services are currently arranged does not create optimal conditions for the delivery of integrated, personal and sustainable community services.

The system complexity impacts on a range of areas particularly for people with the most complex needs where a seamless integrated community system is crucial to their care. Examples include: differing clinical and social policies and organisational governance systems; differing record keeping systems and Information Technology; and many challenges for patients navigating their way through the complex system.

It is also important to recognise that the CCG and the Council are governed by EU procurement law and the Public Contract Regulations 2015. The CCG is further bound by the Procurement, Patient Choice and Competition Regulations 2013. The regulations permit a number of ways in which services can be commissioned, but in each case they require the publication of a call for competition and the conduct of a fair and transparent process prior to the award of the contract.

Option 3: Confirm intent to award to Virgin Care [RECOMMENDED]

Under this option, a specified new model of care would be commissioned to start in April 2017 in line with the outcome of the procurement process.

The service model proposed by Virgin Care is based upon the priorities identified through engagement and consultation with local people and professionals. In addition, the demographic and financial challenges faced by health and care services both locally and nationally have made the current service model unsustainable.

Virgin Care has been selected as preferred bidder because they have an ambitious but realistic plan for transforming local services so that people experience care that is more personalised, more coordinated and focussed on prevention and self-care.