Multi-speciality Community Provider (MCP) in Stockport

Options Appraisal of Organisational Form

17 October 2016
FINAL VERSION

Purpose of this document

The four Providers of Health and Social Care in Stockport are now reaching a milestone in the procurement process to identify the potential organisational form of a Multi-speciality Community Provider (MCP) in Stockport. The purpose of this document is to present the options that have been considered, including the relevant information required to support members of each partner provider organisation (Stockport NHS Foundation Trust, Stockport MBC, Viaduct Health and Pennine NHS Foundation Trust) in identifying a preferred option.

This document provides an overview of the strategic context in the development of a MCP in Stockport and outlines the appraisal undertaken by providers leading to a recommendation of a preferred option for the MCP form.

Executive Summary

As a result of changing demographics and the way that health and care needs are currently organised and met within Stockport, the Stockport Together Programme has been established. This is a partnership between Stockport Clinical Commissioning Group, Stockport MBC, Stockport NHS Foundation Trust, Pennine Healthcare and Viaduct Healthcare that has been in place for over 12 months.

A key aim of this partnership is to ensure that local health and social care organisations are able to work together in a more joined up way to deliver the new models of care envisaged by the programme. In order to achieve this, the local Joint Commissioners (Stockport CCG and Stockport MBC) have launched a formal process to procure a new type of organisation: a Multi-Specialty Community Provider (MCP) which will be based on the registered GP list and will bring staff from existing health and social care organisations together into a new provider form. This options appraisal is a key component of the overall procurement process.

Stockport NHS Foundation Trust, Pennine Healthcare NHS Foundation Trust, Viaduct Health GP Federation and Stockport MBC have been asked by local Commissioners as part of the MCP procurement described above to identify their preferred option for the future form of organisation that will best support the delivery of the new integrated model of health and social care that has been developed through the Stockport Together Programme over the last 12 months.

In considering this, Providers within Stockport have committed to a two-step process:

1) Options Appraisal – identifying a single preferred option
2) Final Business Case (FBC) - incorporating a detailed analysis and due diligence of the preferred option

This document forms the options appraisal step of this process. A critical component of this stage was the agreement that Provider partners must achieve consensus on a preferred option for it to proceed to a Final Business Case and for it to successfully pass through the various gateways in the procurement and regulatory processes. In addition a preferred form must be capable of delivering the current procurement scope and requirements as set out by Joint Commissioners. Based upon NHS England national guidance regarding the options for form and contractual framework for MCP's, the following five provider forms were considered:

- Contractual Alliance
- New Neighbourhood Led Accountable Care Trust
- Lead Provider (Host)

- Corporate Joint Venture – Community Interest Company
- Limited Liability Partnership

A set of assessment criteria to rate each option was agreed by the Senior Leadership of the four Providers which considered:

- Effective governance and accountability
- Affordability and value for money
- Enables GP influence
- Effective delivery of the new model of care
- Impact on wider health and care workforce

A shared engagement pack was developed by Provider partners which included illustrative outlines of governance arrangements for each form and the appraisal criteria and sub-criterion. This was shared equally across all Provider partners to enable organisations to have an informed and meaningful consideration of each option.

Based on feedback from the Senior Leadership within the four Providers and independent legal advice received from HEMPSONS Solicitors, each component of the assessment criteria has been rated against one of the following three definitions (referred to as hurdle criteria):

- Not possible (legal or procurement framework does not allow)
- Possible but material risk to delivery; and
- Possible and Deliverable

A summary of the outcome of this assessment for each option is set out in the table below:

Hurdle Criteria Assessment			
	Not possible	Possible but a material risk to delivery	Possible and deliverable
Option 1 Contractual Alliance	1	4	17
Option 2 New Neighbourhood Led ACT	0	1	21
Option 3 Lead Provider	1	5	16
Option 4 Corporate Joint Venture	3	14	5
Option 5 GP Led Limited Liability Partnership	3	13	6

Based upon this assessment exercise and feedback received from all partners, a **New Neighbourhood Led Accountable Care Trust** was identified as the single preferred option by all partners to meet the procurement requirements and a collective aspiration to create a new entity with a fresh ethos. Whilst consensus was reached, this option, should it be approved, will still require further consideration and agreement during the Final Business Case (FBC) phase between Providers regarding the appropriate balance of organisational and stakeholder influence within the appropriate governance framework. In addition, it is important to stress that the FBC, once approved by Provider governance processes, would also be subject to the outcome of the Joint Commissioning Procurement process and would require regulatory approval by NHS England and NHS Improvement.

Alongside consideration of the MCP form, has been an aligned exercise to assess the opportunities for support services within Stockport and in particular whether there are opportunities to deliver a more efficient, joined-up and quality support offer. This assessment makes clear that significant further integration of support services is

both practical and viable, could take a range of forms, and would have significant benefits for Stockport MBC, Stockport NHS Foundation Trust and the wider health and care economy. In particular this assessment identifies a preference for a Stockport led approach to support service integration (initially between Stockport MBC and Stockport NHS FT) either through a formal partnership or public to public contracting and has identified a set of design principles to support this work. As with the overarching MCP form appraisal, it is identified that a further more detailed exercise is now undertaken.

The recommendation now presented to Providers to consider and formally approve to proceed with:

- A detailed exercise (including due diligence) to formulate a Final Business Case; and
- Stockport MBC to work with Stockport Foundation Trust to prepare a specification for a structured programme that results in an option for integrated support services

Contents

Section 1 – Strategic Context

1.1 Overview of Stockport Together

Across Stockport, £518m is spent on Health and Adult Social Care. As a result of changing demographics and the way that health and care needs are currently organised and met within Stockport, it is expected that health and social care services in Stockport will have a recurrent financial deficit of £136m (about 25% of its current budget) by 2021. In order to address this, the partner organisations across Stockport (NHS Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust, Stockport MBC and Stockport's GP Federation, Viaduct Health) are working alongside GPs and voluntary organisations to develop a single strategic plan to create sustainable health and social care services across the borough.

Stockport Together's collective vision is ***a sustainable health & care system*** for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. To achieve this we are delivering ***new forms of care*** to specific cohorts of our population through a ***new form of organisation*** constructed from the GP registered list at neighbourhood level and incentivised by a ***new form of commissioning***. This has been supported through the establishment of a shadow Provider Board and an Integrated Commissioning Board during spring 2016.

Stockport Together is also an integral element of the Greater Manchester (GM) Health and Social Care Partnership work. Each "locality" in GM has been required to develop a plan to support the development and implementation of the GM sustainability and transformation programme. Stockport Together, in particular the MCP development, is a significant and core component of this locality plan. The GM transformation fund identifies five 'lots' that reflect the strategic priorities of the conurbation for health and social care. Given the significant scale of Stockport's system level change the development of the MCP will support GM to implement its strategic plan against three of these lots:

- Radical upgrade in population health and prevention
- Transforming care in localities, and
- Enabling better care

This has been recently been supported through the award of £19m transformation fund from GM to Stockport Together.

1.2 Multi-speciality Community Provider Procurement Process

First described in the NHS Five year Forward View, the MCP is a new type of integrated place based provider serving the whole population whose defining feature is the registered list of the participating GP Practices. It is intended to combine the delivery of primary care, community-based health and social care services and the provision of some services currently based in hospitals such as the Emergency Department, diagnostics and out-patients. The building blocks of an MCP are the 'care hubs' of integrated neighbourhood teams with each neighbourhood typically serving a community of around 30-50,000 people.

In July 2016, national guidance was produced by NHS England[1] regarding the options for form and contractual framework for MCP's. This stated that an MCP will need to be a formal legal entity, or group of entities acting

[1] The multi-specialty community provider (MCP) emerging care model and contract framework

together to form the MCP, that is capable of bearing and managing financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance.

Stockport has already put in place a pooled budget of £200m. This built on existing Section 75 arrangements[2] and forms the foundation of integrated provision and commissioning. The four Providers have also signed a memorandum of understanding (MOU) to regulate their joint working and have established a Shadow Provider Board as the focal point for these arrangements. Stockport's Integrated Commissioning Board formally instigated a procurement process for an MCP on 14 April 2016. This was carried out under Regulation 118, of the Public Contracts Regulations 2015. As part of this procurement process, the four providers have been asked during 2015/16 to identify their preferred option in terms of form for the proposed new entity.

The Shadow Provider Board has adopted a two stage approach to this process. Firstly, the identification of a preferred option through an options appraisal exercise which is to be completed by the end of November 2016 following appropriate organisational consideration. This is to be followed by a Final Business Case (FBC) incorporating a detailed analysis and due diligence of the preferred option. The FBC, once approved by Provider governance processes, would also be subject to the outcome of the Joint Commissioning Procurement process and would require regulatory approval by NHS England and NHS Improvement. This document forms the options appraisal stage of this process.

1.3 Scope

As part of the procurement process, the Joint Commissioners (Stockport CCG and Stockport MBC) have confirmed the following criteria for determining the initial service scope of the MCP:

- Provided to the Stockport population aged 65 or over
- Funded by Stockport CCG
- Currently provided by Provider Board members; and
- Within scope of the budgets to be pooled or aligned by Stockport CCG and Stockport MBC

With these criteria as a point of reference, the in-scope services to the proposed MCP have therefore been identified (to be either directly delivered or through sub-contracting) and these are summarised in *Fig.1.* on the next page.

The appraisal process has been conducted on the basis of this service scope and configuration. If the appraisal process resulted in an outcome that there is no form able or suitable to deliver this scope of services then the proposed scope may need to be revisited.

[2] An agreement made under section 75 of the NHS Act 2006 between the Local Authority and the CCG to pool resources and delegate certain NHS and LA health related functions to the other partner.

Fig. 1. Diagram showing 'in- scope' services

The indicative financial value of these in scope services is £180m.

1.4 Purpose of the Options Appraisal

The purpose of the options appraisal was for each Provider to receive consistent information regarding the options identified for the MCP form, allowing for debate and consideration during an 'engagement phase' with each Provider organisation. Following this period of engagement and feedback from each Provider, an assessment has been made of each option against an agreed set of assessment criteria.

This engagement phase was to refine and agree the proposed options listening to the feedback of each Provider. Ultimately, Provider members will be asked to select a preferred option for the configuration of an MCP in Stockport.

This document makes a recommendation of a single preferred option to be taken forward to the next stage; development of a FBC and proceeding to due diligence of the preferred option.

The options appraisal does not seek to make future assumptions and this decision **is not contractually or legally binding on any Provider.**

This document outlines the following:

- The legal options for organisational form that are being considered for the proposed MCP
- The potential governance and decision making structure of each option
- The options appraisal assessment and decision making criteria
- The outcome of the options appraisal based on a summary assessment from the four Provider organisations during the 'engagement phase'

- A recommendation of a single preferred option; and
- The next steps and a timeline to decision

1.5 Options presented during engagement and consultation

A shortlist of five options was identified for presentation in the engagement phase. This shortlist was generated through a review of the NHS England guidance which outlined that an MCP will need to be:

- A formal legal entity, or group of entities acting together to form the MCP
- That is capable of bearing and managing financial risk; and
- Which has clear governance and accountability arrangements in place for both clinical quality and finance

The existing Providers agreed to adopt the principle of using one set of joint legal advice to develop this options appraisal – this was secured from HEMPSONS Solicitors.

The options presented and considered by the Providers during the engagement phase are shown below:

- Option 1 - Contractual Alliance
- Option 2 - New Neighbourhood Led Accountable Care Trust
- Option 3 - Lead Provider (Host)[3]
- Option 4 - Corporate Joint Venture: Community Interest Company
- Option 5 - Limited Liability Partnership

Outlined in the following section is a detailed description of each option in light of how it would work to deliver the MCP, including an overview of the potential governance structure and decision making arrangements. It should be noted that the diagrams in relation to governance and decision making are purely illustrative at this stage and are not intended to represent an actual proposal. The precise governance arrangements for the preferred option would require further detailed discussion and agreement at FBC stage.

[3] Lead Provider was not in the initial shortlist of options originally published by the Shadow Provider Board but was later added in order to ensure alignment with national NHS guidance

1.5.1 Option 1 – Contractual Alliance

Overview

- The four Providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, an MCP contract is not let instead the alliance would overlay existing contracts

- The Joint Commissioners and four Providers come together in a contractual alliance to deliver MCP services under their existing contracts with the commissioners

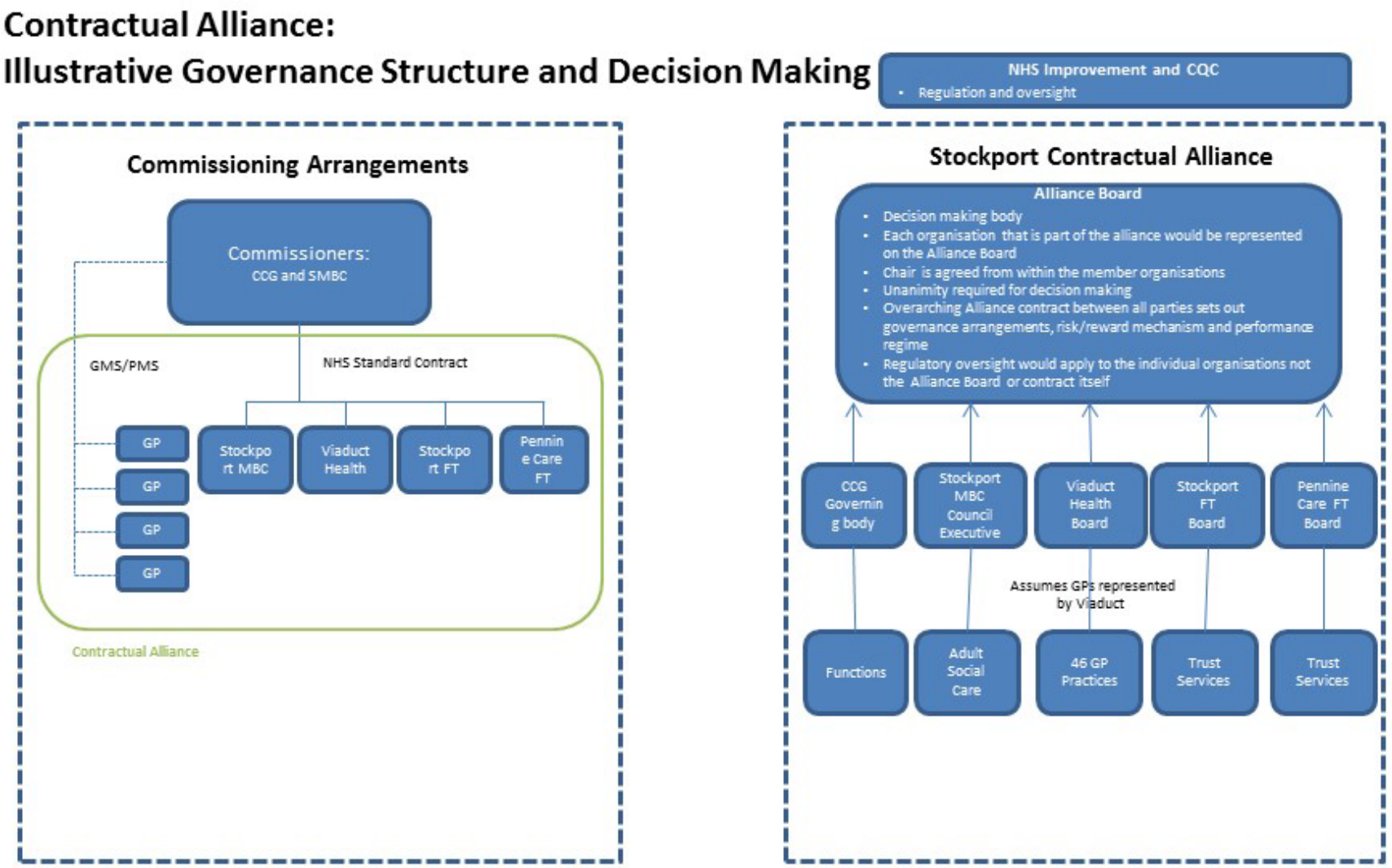
- Decision making by the four Providers is delegated from each provider to their member(s) who sit on an Alliance Board and bind their organisation

- An overarching robust alliance arrangement which deals with risk and reward sharing is put in place

- Services are delivered by the individual members under their existing contracts

- The joint commissioners (CCG and Stockport MBC) act as system integrators

Fig. 2. Contractual Alliance illustrative governance structure and decision making



1.5.2 Option 2 – New Neighbourhood Led Accountable Care Trust

Overview

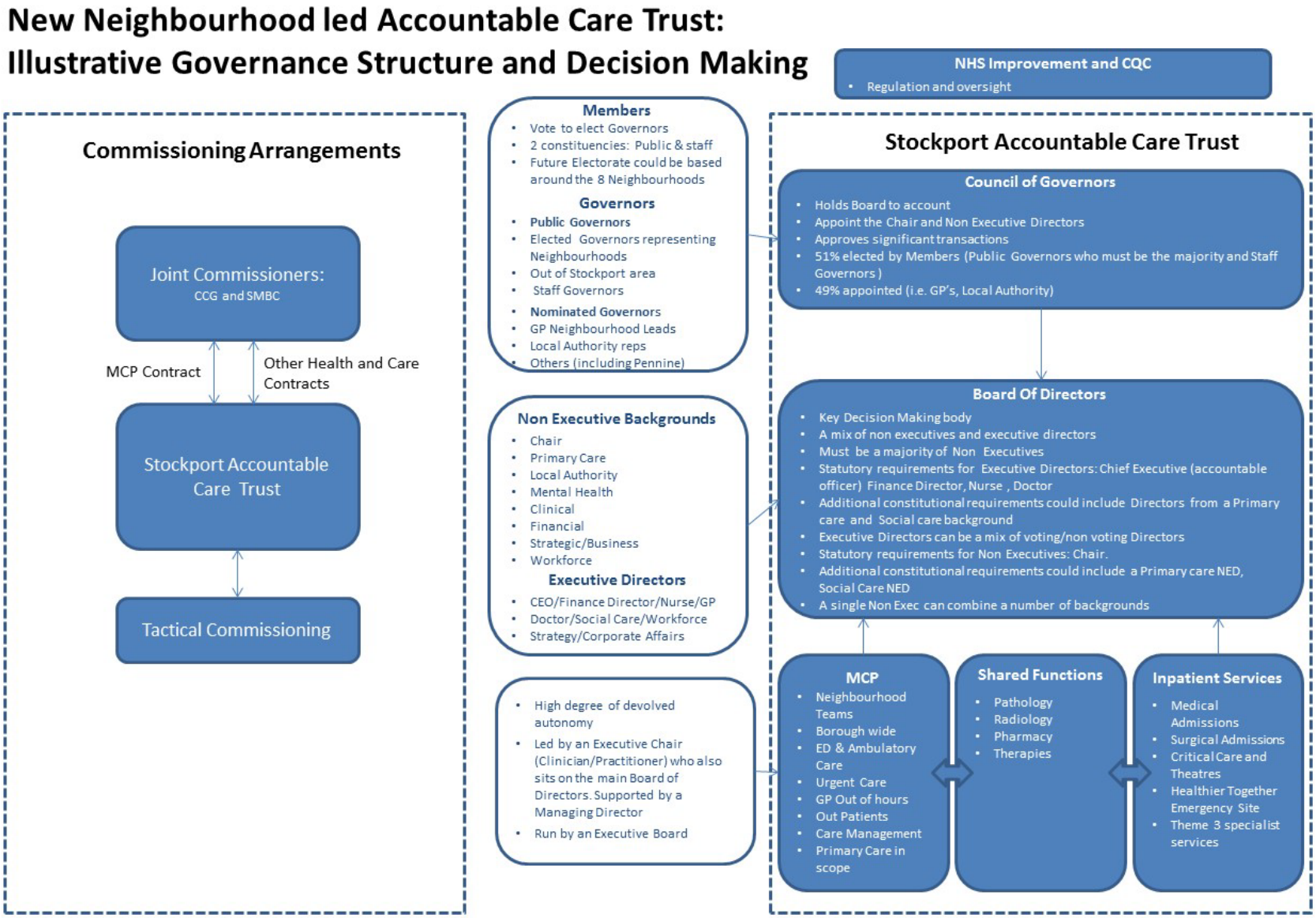
- A new Neighbourhood led Accountable Care Trust for Stockport is created jointly by Stockport NHS FT and Stockport MBC using the legal framework of the existing Stockport FT. The new entity will hold the MCP contract as well as all other contracts for local legacy health and care services thereby creating a single Health and Care Organisation for Stockport

- Stockport NHS FT and Stockport Metropolitan Borough Council would use their powers under section 77 of the 2006 Health Act to create a Care Trust. Care Trusts have been established to bring together in one legal entity the commissioning and provision of health and social care services. Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services

- New governance and leadership arrangements are put in place which satisfy all partners and regulatory bodies

- Satisfies the requirement set out by the Joint Commissioners in the Procurement Process to create an organisation built from the registered GP list and to enable GP leadership at Governor, Board, Executive, Managerial, Hospital and Neighbourhood level

Fig. 3. New Neighbourhood Led Trust illustrative governance structure and decision making

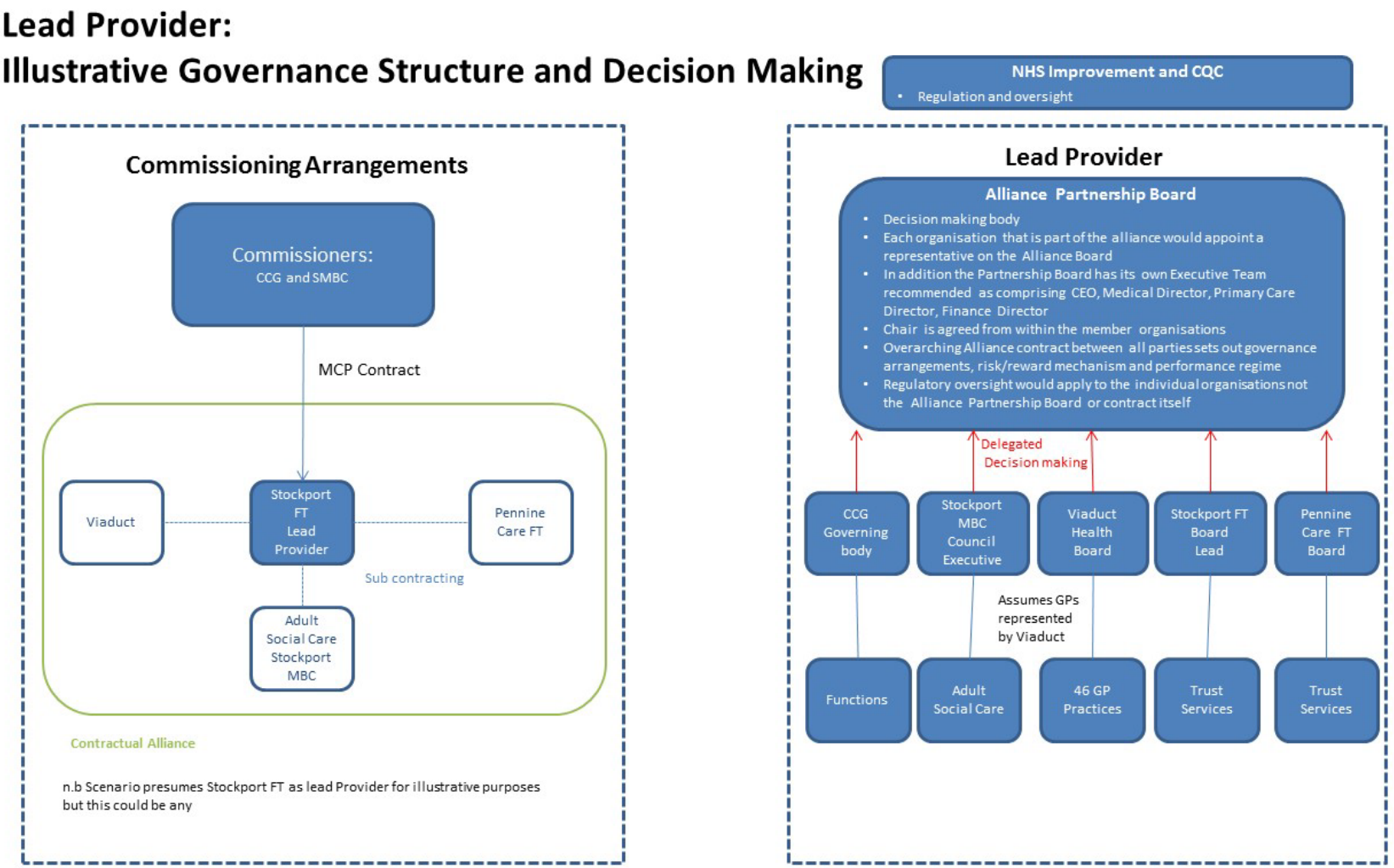


1.5.3 Option 3 - Lead Provider (Host)

Overview

- One Provider acts as the host, holding the MCP contract on behalf of the alliance of four providers
- Activity is delivered by the contract holder (the lead provider who is ultimately responsible) and sub contracted to other Providers
- Risk and reward are shared through agreed contractual arrangements, the alliance arrangement would need to be sufficiently strong to effectively pass risk and reward between the alliance partners
- Decision making by the Providers is delegated from each provider to their member(s) who sit on the Alliance Partnership Board and bind their organisation
- The Alliance Partnership Board has its own Executive Team recommended as comprising; Chief Executive Officer, Medical Director, Primary Care Director, Finance Director

Fig. 4. Lead Provider illustrative governance structure and decision making

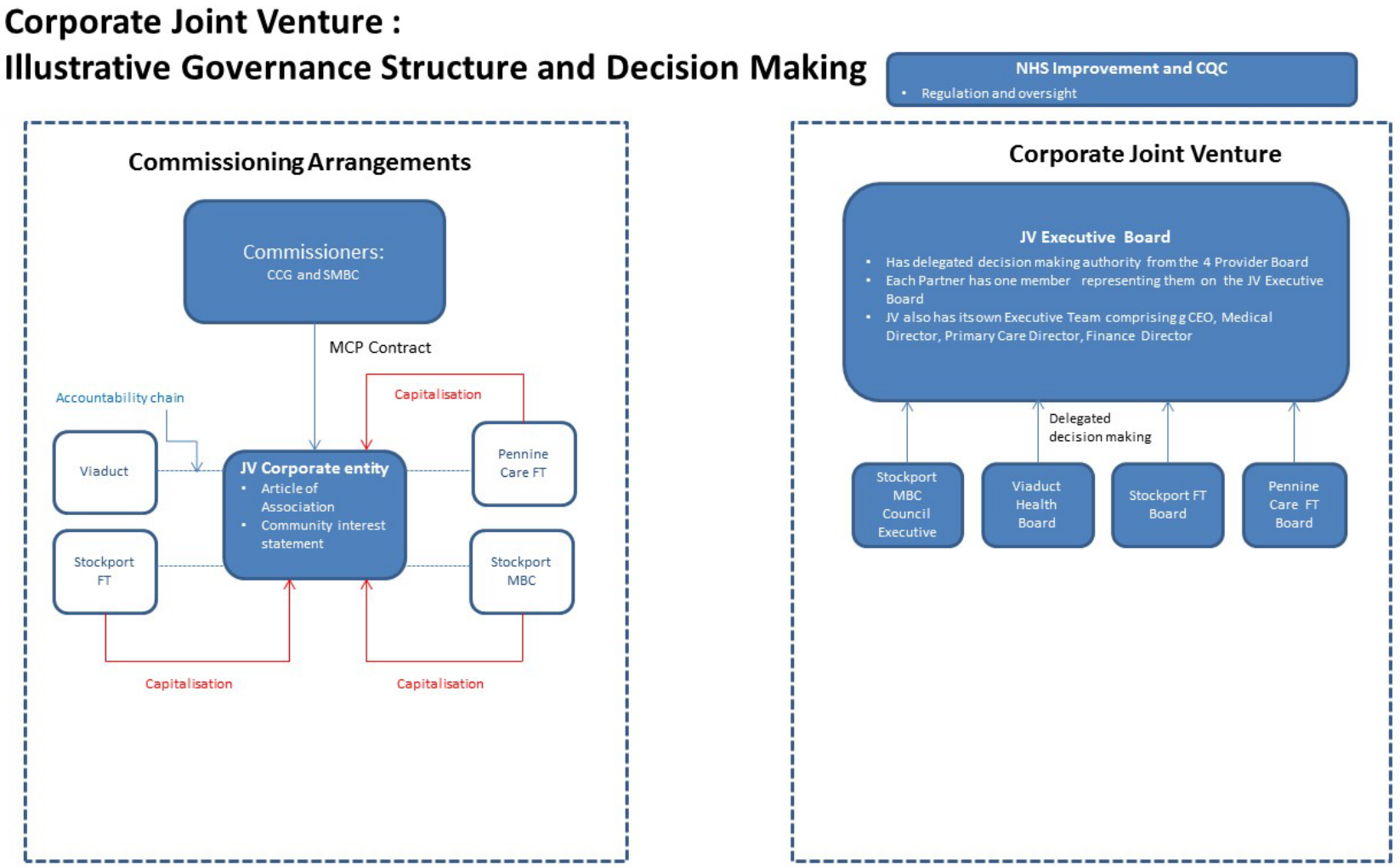


1.5.4 Option 4 - Corporate Joint Venture: Community Interest Company

Overview

- The four Providers partner in a corporate joint venture which holds the MCP contract
- The company is established as a company limited by shares which is also a Community Interest Company
- The two Foundation Trust's and Council provide working capital for the Joint Venture
- Viaduct could put in no capital or a nominal amount with potential consequences for their level of reward and/or control of the entity
- Control of the Community Interest Company is divided between the four providers
- GPs agree that Viaduct represents their views as shareholders
- Regulators would need to confirm that they are content with both Foundation Trust's approach through a Transaction review

Fig. 5. Corporate Joint Venture illustrative governance structure and decision making

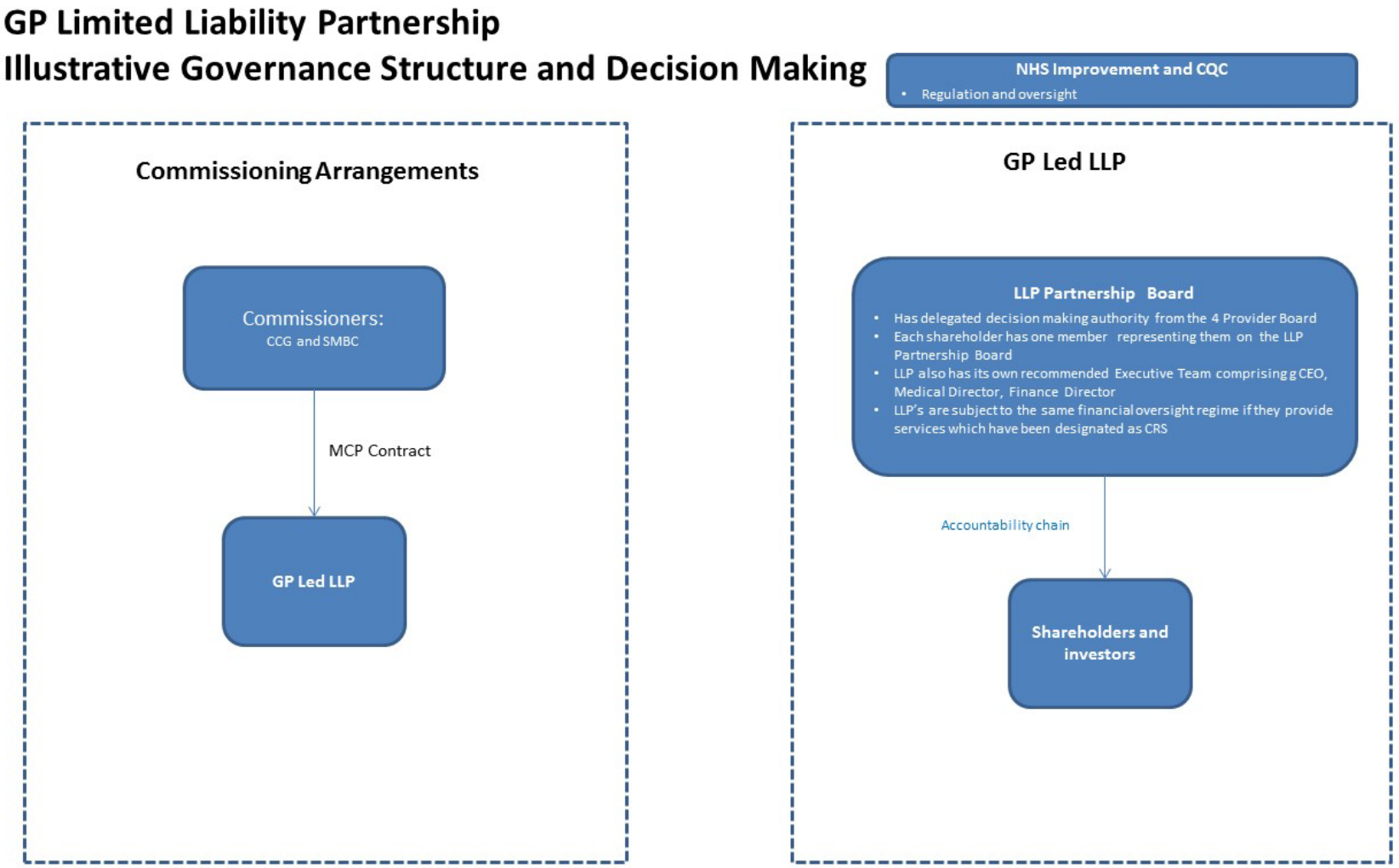


1.5.5 Option 5 - Limited Liability Partnership

Overview

- GP's form a legal entity (an LLP) to hold the MCP contract with working capital provided by the Private Sector
- The Independent sector provider regulatory framework applies
- Governance and decision making mechanisms would be clearly stated in an LLP agreement between the parties involved

Fig. 6. Limited Liability Partnership illustrative governance structure and decision making



1.6 Support Services

Alongside the appraisal of options for future MCP organisational form, consideration can also be given to the design of support services for the new entity. Such an approach would enable Stockport Together partners to enhance the quality and efficiency of support services across relevant partner organisations, whilst also ensuring that appropriate arrangements are in place to support the process of transition itself.

Therefore, in parallel to the Provider form options appraisal an initial aligned piece of work has commenced to establish a baseline of support service operations across partner organisations; provide a critical appraisal of options for change; and propose recommendations and a roadmap for reform. This initial perspective forms section 4 within this document.

Section 2 – Appraisal Methodology

This section describes the methodology adopted during this initial appraisal stage. This includes an overview of the engagement process, appraisal criteria and organisational governance arrangements.

2.1 Engagement process

Stakeholder engagement is a central component to the approach undertaken during this appraisal. To support this, a series of engagement activity was planned with each organisation. The purpose of engagement at this stage was to agree the appraisal criteria against which to assess the options based on legal advice from HEMPSONS and then to work with senior leadership teams within Providers to identify a clear preference which had the agreement of all Provider partners. To support the engagement the following principles were followed:

- In order to progress this appraisal all organisations must ***reach a consensus*** and therefore no form could be recommended without all organisations being in agreement
- This period of engagement was to ***identify a preference*** across Provider organisations within Stockport and therefore the outcome of the options appraisal is not contractually or legally binding on any partner
- ***Transparency*** was key to ensuring trust and equitability between Partners and therefore all Partners received the same engagement pack and had the opportunity to contribute and feedback on its contents, including the assessment criteria; and
- A ***commitment to further engagement or consultation*** which will form part of the second stage of this work during the Final Business Case phase. The extent and approach of which will be determined in line with the organisational form preference reached by Provider partners

Engagement was carried out in four phases as shown in *Fig. 7.* below.

Fig. 7. Engagement phases

Phase	Purpose	Engagement Products	Audience
Inform	To inform key stakeholders of the purpose of the appraisal and the approach that would be undertaken	Briefing note circulated to all partners, affected staff and unions, public facing governing meetings	Staff; Unions; Partner Governing Bodies; Scrutiny; Public
Form Appraisal	To enable Provider Partners to: • Feedback on the appraisal criteria and governance options individually and collectively. • Assess each option against the agreed criteria • Arrive at a consensus regarding a	Stakeholder engagement sessions with Senior Leadership within each provider supported by jointly commissioned legal advice *(dates of which are outlined in Fig. 8.)* Engagement Pack - this pack was updated during the engagement process to reflect feedback received from Providers and included the following sections: • Purpose	Provider Partners

Phase	Purpose	Engagement Products	Audience
	recommended preferred option	• Outline of the appraisal report *(this report)* • National guidance for development of an MCP • Services in scope • Realistic options to be considered by Providers • Options appraisal assessment criteria • Overview of each option including illustrative governance and decision making • Decision timeline All of the content from this pack has been incorporated into the options appraisal report *(this report)*	
Recommendation Agreement	To enable Provider Partners to feedback on draft report and to ensure Unions had early sight of consensus reached by Partners	Circulation of draft options appraisal report *(this report)*	Provider Partners; Unions
Formal Engagement and Decision Making	To enable formal consideration of the appraisal document and recommendation	Options appraisal report, published to all Partners on 17th October *(this report, dates included in section 6)*	Formal Partner Organisational Governance routes

A timeline of stakeholder engagement is outlined in *Fig. 8.* below. Feedback received during this engagement approach has been core to the entire option appraisal exercise as set out section 3.

Fig. 8. Stakeholder Engagement Process

	Cross-cutting	Stockport FT	Stockport MBC	Viaduct Health	Pennine Care FT
September 2016	**7 September** Stockport Together Leaders Group **7 September** Stakeholder briefing note disseminated to the key Stakeholders of all organisations **12 – 16 September** Individual Partner Engagement Sessions with Senior Leadership Teams **4th October** Consensus Meeting CEO's Provider Organisations	**21 September** Council of Governors briefing **29 September** Board Strategy Session	**13 September** Health & Wellbeing Scrutiny **14 September** All members briefing **19 September** Adult Care Scrutiny **20 September** Corporate Resources Management and Governance Scrutiny	**21 September** Leadership Council **22 September** Board Meeting	**28 September** Board of Directors

2.2 Appraisal Assessment Criteria

A set of assessment criteria was developed in agreement with the Senior Leadership teams in Provider organisations and was supported by legal advice from HEMPSONS solicitors. This allowed for objective consideration of each option.

This criteria is formed of five key themes, aligned to what an MCP should deliver:

- Effective governance and accountability
- Affordability and value for money
- Enables GP influence
- Effective delivery of the new model of care
- Impact on wider health and care workforce

A set of sub criteria supports each of the five assessment criteria themes. The full assessment criteria can be found in *Fig. 9.* on the next page

Fig. 9. Assessment Criteria

Assessment criteria		Description
1. Effective Governance and Accountability		
1a.	Stakeholder Influence	Allows all four organisations (SFT, SMBC, Pennine FT, Viaduct) the ability to exercise effective influence over decision making
1b.	Professional Governance and Outcomes	Allows the effective delivery of professional (including clinical and practitioner) governance and outcomes
1c.	Regulation	Is established to ensure clear regulatory accountability. Appraisal should outline impact on regulation and how this form would be regulated
1d.	Legal	Meets statutory frameworks including NHS and Local Government frameworks, procurement law and competition law barriers and opportunities
1e.	Ownership	Ownership may be public, franchised or private. Form of ownership is acceptable to the stakeholders and public and is clear and accountable
1f.	Organisational Sustainability	The form must be a robust vehicle which is sustainable and able to stand up and respond to political/regulatory changes/challenges
1g.	Branding	Will give the best branding value for Stockport
2. Affordability and Value for Money		
2a.	Deficit Budget Setting	The form must be able to sustain a deficit budget and hold financial risk over and above a financial year.
2b.	TAX/ VAT/Insurance/ Procurement/Charging Implications	The implications are understood and are affordable and in line with statutory frameworks and reputational considerations
2c.	Transition Costs	Costs are fully understood and are affordable
2d.	Wider public sector/system pressures	Wider cost implications (beyond those areas in scope) resulting from the implementation of this form are understood and are acceptable
2e.	Risks and Benefits	Able to manage risks and benefits, particularly financial
3. Enables GP Influence		
3a.	Practice Based Population	Is built from the registered GP list
3b.	GP Leadership	Enables GP management, leadership or ownership. Complies with NHS E guidance on GP engagement and leadership
4. Effective delivery of the new model of care		
4a.	Scope of Services	Delivers the scope of services identified by stakeholders
4b.	Service User/Patient Choice	Enables providers to maintain choice for services users and a plural market
4c.	Transition Timeframes	Able to transition to new form in line with timeframes identified for the new models of care
4d.	Responsiveness	The model is able to make responsive decisions in relation to patient care
4e.	Service User/Patient Experience	Enables delivery of quality services
4f.	Alignment with other Strategies	Including GM and local strategies
5. Impact on wider health and care workforce		
5a.	Terms and Conditions	Impact on workforce terms and conditions is understood and acceptable
5b.	Pensions	Impact on workforce NHS and LGS pension schemes' membership is understood and acceptable

2.3 Organisational governance and decision making

There are two decision making points to be considered by the Provider organisations involved. These are the options appraisal (this report) which is to be considered for approval in November 2016 and the Final Business Case (FBC) which will be constructed at a later point dependent upon the option selected and work involved.

The options appraisal is a detailed assessment of each of the realistic options of potential organisational form that are available to the Providers at present. These have been considered and analysed as part of the engagement phase, using the following key principles as a guide:

- Whether they address the business needs – whether they improve the current system, deliver the requirements of the procurement
- What benefits they bring – whether they support the new model of care and bring patient quality and experience benefits, whether they are more cost effective, whether they enhance recruitment, well-being and productivity of staff
- What risks they bear – identification of the key business and service risks during design, implementation and operationalisation of the new form
- The constraints involved – the issues that restrict the delivery of the objectives, in particular the effect on other services and organisations and the time to deliver
- The opportunities and challenges they present to the partner organisations in respect of their other functions and the extent to which they complement their core values and principles

As outlined in section 1.6 this report has also considered the impact and opportunities relating to support services. This appraisal will be found within section 4 of this report.

This options appraisal will be subject to approval by the following organisational governance:

- Stockport Council Executive – public meeting
- Stockport Foundation Trust Board meeting – public meeting
- Stockport Foundation Trust Council of Governors – public meeting
- Pennine Care Foundation Trust Board Meeting – public meeting
- Viaduct Board meeting – private meeting

Section 3 – Options Appraisal

This section describes the options appraisal that has been completed, this includes:

- The rationale for the criteria and how this has been applied to the assessment
- The options and the assessment of these at sub-criteria level based on the feedback received from Providers in the engagement phase; and
- How this has informed the recommended option for further decision making and development of a Final Business Case

3.1 Assessment criteria

An "option" describes the potential organisational form under which an MCP will be delivered. A set of 'hurdle criteria' has been established to provide an objective a view as possible of the options against each sub-criteria. It is acknowledged however that this may be open to interpretation. This hurdle criteria has been applied to the assessment criteria based on the feedback from each provider. A visual indicator known as a RAG rating (Red, Amber and Green) is used for the application of the hurdle criteria against each sub-criteria - these are categorised as per the table below.

Fig. 10. Hurdle Criteria Indicators

Indicator	Description
	Not Possible (legal or procurement framework does not allow)
	Possible but material risk to delivery
	Possible and Deliverable

An assessment table has been created for each option which shows the hurdle criteria indicator assigned to each sub-criteria with assessment notes, explaining the rationale for the Provider's view. Accompanying this is a narrative summary of each option following the headings below:

- **Effective Governance and Accountability:** Assessment of governance, legal and procurement considerations, including a response to core questions: does this form meet the commissioning requirements; does this form enable effective governance which is suitable to all provider organisations; and, does this form work within all appropriate regulatory frameworks.
- **Value for Money (VfM) and Affordability:** Assessment of financial considerations and specific consideration of ability to deliver sustainability. Including a response to core questions: Can this form manage financial risk over 12months?
- **Enables GP Influence:** Assessment of extent and effectiveness of GP influence within the new Form.
- **Effective Delivery of the New Model of Care:** Assessment of the form to deliver the new model of care to the pace, quality and ambition required.
- **Impact on Wider Health and Care Workforce:** Assessment of the impact on workforce, including specific implications for example terms and conditions.
- **Statement of Appraisal:** Final statement of recommendation/preference

3.2 Assessment of option 1 - Contractual Alliance

Fig. 11. Detailed appraisal for Option 1 – Contractual Alliance

Option 1 - Contractual Alliance			Assessment
1. Effective Governance and Accountability			
1a.	Stakeholder Influence		Equity amongst partners is retained as there are no changes to organisational boundaries. Within a formal alliance there is flexibility on how partners are represented within the governance structure and a defined decision making process can be made legally binding on all organisations within the alliance. This model also enables Elected Members to have a clear democratic accountability through existing democratic structures. However, there is a risk of conflicts of interest developing between the representation of individual organisations and the Provider Board. In addition the model is fragmented with multiple contracts and decision makers which adds complexitiy and reduces effectiveness to the governance structure.
1b.	Professional Governance and Outcomes		Whilst there are no changes to organisational boundaries, and thus clinical and professional governance remains unchanged, there is a risk that this would be more complicated than within a single organisation.
1c.	Regulation		This form will require no change to existing regulatory arrangements.
1d.	Legal (including compliance with commissioning)		The current statutory and regulatory frameworks wouldn't allow an alliance to function as 'one' organisation. This model does not fulfil the local commissioners requirement for a single entity as outlined within the current procurement process. Whlist a contractual alliance is a legal accountable framework, the local commissioners have made it clear that this would only be acceptable on a transitional basis towards a single organisational form.
1e.	Ownership		Ownership and accountability are retained within a public sector form and therefore are anticipated to be more acceptable to all parties including elected members and staff.
1f.	Organisational Sustainability		Due to the contractual alliance not being a single entity each provider organisation would retain its own priorities and objectives. This could compromise the sustainability of the alliance due to conflicting priorities and objectives between providers. In addition the existence of multiple lines of governance and accountability would present a significant risk to the sustainability of the opersational delivery of services.
1g.	Branding		It would be possible to develop a brand which is acceptable to all partners and which embodies the new MCP.
2. Affordability and Value for Money			
2a.	Deficit Budget Setting		There are no changes to organisational boundaries and therefore existing deficit budget arrangements remain in place. However the balance of risk and gain share would need to be agreed and set out in the alliance in order to make this form effective.
2b.	TAX/ VAT/Insurance/ Procurement/Charging Implications		There are no implications or changes to arrangements anticipated as current organisational boundaries remain unchanged.
2c.	Transition Costs:		The transition costs for this form would be low as there are no changes to organisational boundaries.
2d.	Wider public sector/system pressures		There are no changes to organisational boundaries and therefore there are no unintended consequences for out of scope services. Due to multiple organisational forms this is a less cost effective or efficient model due to duplicated corporate costs and overheads. This may contribute to public sector or system wide pressures.
2e.	Risks and Benefits		Due to multiple lines of governance and accountability there is an increased risk to the delivery and realisation of benefits.
3. Enables GP Influence			
3a.	Practice Based Population		This form can be built from the registered GP list.
3b.	GP Leadership		GPs can be represented on partnership board with influence over strategy and decision making. However, GP influence across the system may not be as strong as there is no change to individual organisational forms and remits.

4. Effective delivery of the new model of care		
4a. Scope of Services		This form could deliver all in-scope services.
4b. Service User/Patient Choice		Organisational boundaries will not change and therefore the existing level of service user/patient choice will remain.
4c. Transition Timeframes		This form is considered easy to set-up and as such it would be possible to transition to an alliance quickly and therefore meet implementation timescales.
4d. Responsiveness		There may be lack of alignment between those services in scope and out of scope. Conflicting organisational priorities could adversley impact the outcome for patients and service users.
4e. Service User/Patient Experience		
4f. Alignment with other Strategies		It is not anticipated that this model will meet the national NHS objective of a single integrated provider of an MCP contract.
5. Impact on wider health and care workforce		
5a. Terms and Conditions		Likely to be more acceptable to workforce as no change to employment status; Retention of existing organisational structures potentially limits flexibility to innovate with workforce across the alliance
5b. Pensions		

3.2.1 Contractual Alliance Commentary

Building on the detailed appraisal set out above; outlined below are a series of summary conclusions set against the criteria.

3.2.2 Partnership Consensus

The following headline comments were made by Provider partners:

- Democratic accountability of services is important and this option would ensure this
- A Contractual Alliance could be used as a transitional form; and
- Any new model would need to; be a single organisation in order to deliver the scale of transformation required in Stockport, meet commissioners stated procurement requirements and reduce corporate overhead costs

3.2.3 Governance and Accountability Assessment

Overall assessment: Not possible

The current statutory and regulatory frameworks do not allow an alliance to work as 'one' organisation. This model is not in line with the national NHS policy guidance for a single integrated provider and does not fulfil the local commissioners' requirement for a single entity outlined within the current procurement. Whilst a contractual alliance is a legal accountable framework, local commissioners have confirmed in the procurement process that this would only be acceptable on a short time basis on a journey towards a single organisational form

3.2.4 Value for Money (VfM) and Affordability Assessment

Overall Assessment: Possible but material risk to delivery

Under this option, there are no changes to existing organisational boundaries. However, due to the existence of multiple lines of governance and accountability, there is an increased risk to the delivery and realisation of the benefits anticipated through the implementation of the service model. In addition, the continued existence of a multi provider local economy with its significant corporate costs and overheads would render this a less cost effective and efficient model.

3.2.5 Enables GP Influence

Overall Assessment: Possible and Deliverable
An alliance board would need to be established which could include GP representatives and would enable GP influence over strategy and decision making. This form can also be built from the GP registered list.

3.2.6 Effective Delivery of the New Model of Care

Overall Assessment: Possible but material risk to delivery
The effective delivery of the new model of care could be compromised by the existence of different organisational priorities which could impact person and system level outcomes. It is not anticipated that this model will meet the national NHS objective of a single integrated provider of an MCP contract.

3.2.7 Impact on Wider Health and Care Workforce

Overall Assessment: Possible and Deliverable
As there would be no change to organisational boundaries under this option, existing terms and conditions (including pensions) would remain intact and therefore the impact on the workforce would be minimal.

3.2.8 Overall Statement of Appraisal

One element under effective governance and accountability has been assessed as 'not possible'. A number of other sub-criteria are deemed as 'possible but with a material risk to delivery' and as such this option is **NOT RECOMMENDED**

3.3 Assessment of option 2 - A New Neighbourhood Led Accountable Care Trust

Fig. 12. Detailed appraisal for Option 2 – A New Neighbourhood Led Accountable Care Trust

Option 2 - New Neighbourhood Led ACO		Assessment
1. Effective Governance and Accountability		
1a. Stakeholder Influence		Governance arrangements could be put in place that are acceptable to all partners but this will require further discussion and negotiation of how this could be achieved using a Foundation Trust governance structure. This could include consideration of the composition Council of Governors which allows for representation from staff, local community and patients. In addition, this form would widen partner influence over all aspects of Health and Care. This form does present an additional complexity for the Local Authority in delivering its statutory responsibilities.
1b. Professional Governance and Outcomes		Clear clinical and professional governance could be established within a single NHS form
1c. Regulation		This option is a single organisation with clear and widely understood governance arrangements which are familiar to regulators and national bodies.
1d. Legal		The form can operate within the legislative frameworks for all existing organisations.
1e. Ownership		Ownership and accountability would be retained within a public sector form and therefore is anticipated to be more acceptable to all parties including staff and elected members.
1f. Organisational Sustainability		This form is considered sustainable as it would be developed as a single organisation within an NHS organisational framework which is familiar to regulators and national bodies.
1g. Branding		It would be possible to create a new brand which is agreeable to all partners and embodies the new MCP.
2. Affordability and Value for Money		
2a. Deficit Budget Setting		The governance framework will enable this form to hold financial risk beyond a financial year.
2b. TAX/ VAT/Insurance/ Procurement/Charging Implications		The Foundation Trust is able to provide capitalisation and can do so at relatively low cost. There are positive TAX and VAT implications as this form is not liable for corporation tax and can claim back VAT on contracted out services.
2c. Transition Costs		Transition costs are anticipated such as the cost to change resulting from the harmonisation of terms and conditions of service.
2d. Wider public sector/system pressures		This form would ensure that current Foundation Trust services not in scope would be built in to a new organisational form ensuring ongoing viability and stability across the system. In addition a single organisation would enable Value for Money (VfM) through the opportunity for reduced duplication and corporate overheads through integrated leadership and/ or support services.
2e. Risks and Benefits		Form can hold financial risk beyond a financial year. In addition as a single organisation it mitigates potential complexity arising from risk and benefit share.
3. Enables GP Influence		
3a. Practice Based Population		This form can be built from the registered GP list.
3b. GP Leadership		There is an opportunity with new governance arrangements to build GP leadership at all levels of the organisation, including: Governor, Board, Executive, Managerial, Hospital and Neighbourhood levels. With this form there is no requirement for GPs to provide capital or bear financial risk. There is a risk that this form is percieved as a hospital take-over.
4. Effective delivery of the new model of care		
4a. Scope of Services		This form can deliver all in scope services and is also able to sub-contract up to 49% of non-NHS activity to other providers if necessary.
4b. Service User/Patient Choice		Service User / Patient Choice retained within Stockport.
4c. Transition Timeframes		Will require time to transition to new form but this will be assisted through the use of the existing Foundation Trust governance frameworks.
4d. Responsiveness		As a single organisation this form can break down the barriers that can prevent effective joined up health and care and can ensures delivery of end to end model of care.
4e. Service User/Patient Experience		
4f. Alignment with other Strategies		Form is supported by NHS and thus viewed as more robust and sustainable for the future.
5. Impact on wider health and care workforce		
5a. Terms and Conditions		Workforce remain employed within the public sector and as such it is anticipated that this will be acceptable to Trade Unions and Staff Organisations due to retention of public sector status. Whilst there will be an implication for some staff in moving to a different organisational form (e.g. TUPE), it is anticipated that this is fewer than within alternative models.
5b. Pensions		

3.3.1 A New Neighbourhood Led Accountable Care Trust Commentary

Building on the detailed appraisal set out above; outlined below are a series of summary conclusions set against the criteria.

3.3.2 Partnership Consensus

The following headline comments were raised by Provider partners:

- Governance arrangements could be put in place that are acceptable to all partners but this will require further discussion and negotiation of how this could be achieved using a Foundation Trust governance structure to ensure effective community, primary care and elected representation was in place and that this model could be significantly differentiated from the current Foundation Trust model
- Parity of esteem between mental and physical health should be enshrined within the proposed new organisational form
- Mechanisms would need to be in place through effective governance arrangements to ensure that appropriate control was retained over dedicated funding streams (for example GP Development monies); and
- Partners believe that this model offered the most sustainable option for meeting system-wide financial and service level outcomes. It is a robust vehicle which has a track record of sustainability in the face of the challenges confronting the health and care system. It has the added advantage of being readily understood and trusted by Regulators

3.3.3 Governance and Accountability Assessment:

Overall Assessment: Possible but material risk to delivery

This form can operate within the legislative frameworks for all existing organisations through a single organisation with clear and widely understood governance arrangements familiar to regulators and national bodies. Ownership and accountability is retained as a public sector form and is therefore more acceptable to all parties including staff. As previously highlighted, governance arrangements could be put in place that are acceptable to all partners but this will require further discussion and negotiation of how this could be achieved using a Foundation Trust governance structure.

3.3.4 Value for Money (VfM) and Affordability Assessment

Overall Assessment: Possible and Deliverable

The form has a proven track record of holding financial risk over a year and is sustainable in the face of a challenging financial, political and regulatory climate. A single organisation mitigates the potential complexity arising from risk and benefit share. A single organisation can also deliver better value for money through the opportunity through reduced duplication and corporate overheads.

3.3.5 Enables GP Influence:

Overall Assessment: Possible and Deliverable

A review of existing governance arrangements could be undertaken to enable GP leadership within key governance structures at different levels within the organisation. This form can be built from the GP registered list.

3.3.6 Effective Delivery of the New Model of Care

Overall Assessment: Possible and Deliverable

This form can deliver end to end health and care services within a single form and therefore mitigates the potential complexity of delivery through duplicate organisational form and governance frameworks. Moving to this form would require a transition period; this will be assisted through the use of existing Foundation Trust frameworks.

3.3.7 Impact on Wider Health and Care Workforce

Overall Assessment: Possible and Deliverable

Staff would remain employed within the public sector and therefore it is anticipated that whilst some staff would experience a change that this would affect far fewer staff than in alternative new models.

3.3.8 Statement of Appraisal

There is one element of sub-criteria that is deemed possible but with a material risk to delivery (stakeholder influence). Whilst there would need to be further consideration of the practicalities and detail of each element of this potential form, particularly that highlighted with a risk to delivery, this was the only option deemed acceptable to all provider organisations and is **THEREFORE RECOMMENDED**.

3.4 Assessment of option 3 - Lead Provider (Host)

Fig. 13. Detailed appraisal for Option 3 – Lead Provider (Host)

Option 3 - Lead Provider		Assessment
1. Effective Governance and Accountability		
1a. Stakeholder Influence		There are challenges with the degree of stakeholder influence within this form. With a single lead provider this form may not offer the widest opportunity for stakeholder influence as there is a potential for decision making to be dominated by the host contract holder. As such this would require robust mechanisms for discharging functions and delegated decision making to be developed and agreed. Conflicts of interest between individual organisations and the alliance partnership board may occur as organisational boundaries will remain unchanged. Each Provider believes that given the scale and range of the services in scope, the only realistic lead provider in Stockport would be the Stockport NHS Foundation Trust. Given the collective aspiration to create a new entity with a fresh ethos, Provider partners agreed that this option was no preferred.
1b. Professional Governance and Outcomes		Whilst there are no changes to organisational boundaries, and thus clinical and professional governance remains unchanged, there is a risk that this would be more complicated than within a single organisation.
1c. Regulation		Regulatory considerations would vary depending on the Lead Provider but largely the form can operate within the frameworks for all existing organisations
1d. Legal		The form can operate within the legislative frameworks for all existing organisations
1e. Ownership		Ownership and accountability would be retained within a public sector form and therefore is anticipated to be more acceptable to all parties including staff and elected members.
1f. Organisational Sustainability		System-wide financial risk would ultimately rest on one organisation. In addition this is not viewed as an efficient model due to duplicated organisational forms.
1g. Branding		Branding as a new MCP may be difficult with this form as only part of the MCP services would be within the lead organisaiton which may raise the risk that this is perceived as an organisational takepover by one entity over the others.
2. Affordability and Value for Money		
2a. Deficit Budget Setting		This model can ultimately hold financial risk but a preferred provider would need to be identified by consensus to do this.
2b. TAX/ VAT/Insurance/ Procurement/Charging Implications		There are no implications or changes to arrangements anticipated as current organisational boundaries remain unchanged.
2c. Transition Costs:		The transition costs for this form would be low as there are no changes to organisational boundaries.
2d. Wider public sector/system pressures		It is not anticipated that this is a cost effective or efficient model due to duplicated organisational forms and additional layers of contractual or administrative resources required to service multiple organisations' requirements. This may therefore adversley impact system wide pressures.
2e. Risks and Benefits		System-wide financial risk would ultimately rest on one organisation. Whilst there is an ability to distribute risk through the system this would need to be negotiated and a preferred lead provider would need to be identified initially to enable this. As indicated above there is a corporate cost to servicing multiple contractual arrangements.
3. Enables GP Influence		
3a. Practice Based Population		Can build from Registered GP list
3b. GP Leadership		GPs can be represented on a partnership board with influence over strategy and discussions where decisions are made. Whilst the GP leadership model can be embraced in the same way as in option.2 this may be perceived as less authentic.

4. Effective delivery of the new model of care		
4a. Scope of Services		Scope of services could be delivered by this form but it would ultimately depend on the Lead Provider.
4b. Service User/Patient Choice		Organisational boundaries will not change and therefore the existing level of service user/patient choice will remain.
4c. Transition Timeframes		This form is considered easier to set-up and as such it would be possible to transition to it quickly and therefore meet implementation timescales.
4d. Responsiveness		There may be lack of alignment between those services in scope and out of scope. Conflicting organisational priorities could adversley impact the outcome for patients and service users. In addition, delivering a new model of care for patients through this form may be less responsive due to the need to proceed through contractual rather than managerial routes.
4e. Service User/Patient Experience		
4f. Alignment with other Strategies		This form would align with MCP guidance and GM strategy.
5. Impact on wider health and care workforce		
5a. Terms and Conditions		Likely to be more acceptable to workforce as no change to employment status; Retention of existing organisational structures potentially limits flexibility to innovate with workforce across the system.
5b. Pensions		

3.4.1 Lead Provider (Host) Commentary

Building on the detailed appraisal set out above; outlined below are a series of summary conclusions set against the criteria.

3.4.2 Partnership Consensus

The following headline comments were raised by Provider partners:

- Each Provider believes that given the scale and range of the services in scope, the only realistic lead Provider in Stockport would be Stockport NHS Foundation Trust (FT). Given the collective aspiration to create a new entity with a fresh ethos, Provider Partners agreed that this option was not preferred

3.4.3 Governance and Accountability Assessment

Overall Assessment: Not possible

The form can operate within the legislative frameworks for all existing organisations. There would, however, be a perception of organisational takeover by one entity over the other providers. As stated above, given the scale and range of the services in scope, the four Providers believe that the only realistic lead provider in Stockport would be Stockport NHS FT. This was not preferred by any Provider (including the FT itself) given the collective aspiration to create a new entity with a fresh ethos.

A single lead provider may also not offer the widest opportunity for stakeholder influence and the following issues are highlighted:

- Potential conflicts of interest between individual organisations and the alliance partnership board
- Potential for decision making to be dominated by the host contract holder
- This option would require robust mechanisms for discharging functions and delegated decision making to be developed and agreed

3.4.4 Value for Money (VfM) and Affordability Assessment

Overall Assessment: Possible but material risk to delivery

It is not anticipated that this is a cost effective or efficient model to operate due to duplicated organisational forms and the additional layers of administrative and managerial resources required to service multiple sub contractual arrangements. System-wide financial risk would also ultimately rest on one organisation and whilst there is an ability to distribute risk through the system, this would need to be negotiated and a preferred lead provider would need to be identified initially to enable this.

3.4.5 Enables GP Influence Assessment

Overall Assessment: Possible but material risk to delivery

Board level GP representation, without the need to bear any financial risk or put forward capital, would enable GP influence over strategy and decision making. However, whilst the GP leadership model can be embraced in the same way as with an Accountable Care Trust (option 2), based on feedback from Provider organisations this may be perceived as less authentic. This form can be built from the GP registered list.

3.4.6 Effective Delivery of the New Model of Care Assessment

Overall Assessment: Possible but material risk to delivery

This form can deliver all in scope services. There is however, a risk that responsiveness would be slower and more cumbersome than other options due to the need to proceed through contractual rather than managerial routes. A Lead Provider model would enable clear accountability for delivery of the new Model of Care but duplication and organisational boundaries would remain a significant risk to delivery.

3.4.7 Impact on Wider Health and Care Workforce Assessment

Overall Assessment: Possible and Deliverable

As there would be no change to organisational boundaries under this option, existing terms and conditions (including pensions) would remain and therefore the impact on the workforce in this respect would be minimal.

3.4.8 Statement of Appraisal

One element of the sub criteria is deemed ‘not possible’ and seven are deemed ‘possible but with a material risk to delivery’. Each Provider believes that given the scale and range of the services in scope, the only realistic lead provider in Stockport would be Stockport NHS FT. Given the collective aspiration to create a new entity with a fresh ethos, Provider partners agreed that this option was not preferred. It is not anticipated that this is a cost effective or efficient model due to duplicated organisational forms and additional layers of contractual or administrative resources required to service multiple organisations' requirements; as such **this option is NOT RECOMMENDED**.

3.5 Assessment of option 4 - Corporate Joint Venture (CJV): Community Interest Company (CIC)

Fig. 14. Detailed appraisal for option 4 – Corporate Joint Venture: Community Interest Company

Option 4 - Corporate Joint Venture		Assessment
1. Effective Governance and Accountability		
1a. Stakeholder Influence		Form can be easily established and structured to deliver MCP contract. In particular there are flexibilities on governance as there are no formal requirements in how such entities are governed. However it is not anticipated that this model can be as democratically accountable as other forms which will pose an additional complexity for the Local Authority in delivering its statutory responsibilities. A further consideration is that if the proportion of capital input dictated an individual provider's board representation this would not enable equitable representation and influence from all partners, in particular GP representation and influence. Complications can also arise from a CJV governance from the potential for conflicts of interest between the CJV partners and members of the CIC board, where senior employees of the JV partners sit on the CIC board.
1b. Professional Governance and Outcomes		Clear clinical and professional governance could be established within a single form
1c. Regulation		This form has an impact on the Foundation Trust's regulation due to size and scale of the services involved.
1d. Legal		This form can operate within existing legal frameworks.
1e. Ownership		Because of the scale and scope of the MCP, it is anticipated that there is likely to be potential political and public opposition to non-public sector ownership.
1f. Organisational Sustainability		There is a risk that this vehicle will not be sustainable and able to respond to political/regulatory changes/challenges. In particular relating to the current financial context of the system and the ability of this form to hold financial risk.
1g. Branding		It would be possible to create a new brand however there is likely to be opposition to a new form which falls outside of public sector branding.
2. Affordability and Value for Money		
2a. Deficit Budget Setting		The ability of this form to manage financial risk and bear system deficit is a significant challenge due to requirements of the Insolvency Act and the scale of the current system deficit. Parent company guarantees would be required to back JV. It would be unlikely that current providers would be able to do this following due diligence.
2b. TAX/ VAT/Insurance/ Procurement/Charging Implications		There is a VAT implication as NHS bodies which hold a sub contract from a non NHS body will not be able to recover VAT for contracted out services. This is likely to incur a cost to the system.
2c. Transition Costs:		Transition costs are anticipated for example through the harmonisation of terms and conditions of service. In addition the cost of private capital may be higher than public capital if required to establish this form.
2d. Wider public sector/system pressures		Increased independence of the organisation puts a greater risk on legacy services across the health and social care system. This poses a significant risk to affordability and sustainability of those services not in scope.
2e. Risks and Benefits		Financially more risky due to CJV financial frameworks. In addition one or more partners are unable or unwilling to bear financial risk.
3. Enables GP Influence		
3a. Practice Based Population		Can build from Registered GP list
3b. GP Leadership		The flexibilities associated with this governance arrangement mean that GPs can take-up roles throughout the organisation, including as: Directors, Stakeholders, Employees or a combination of these roles. There is no requirement for GPs to provide capital or bear financial risk but they do have the option to provide capital in return for gain (up to the dividend limit). However, if the proportion of capital input dictated an individual provider's board representation this would not enable equitable representation and influence from all partners. As such, the level of GP control may be limited by the Foundation Trust and SMBC requesting or requiring a veto as the principal providers of capital and risk bearer. Given the current financial position of statutory organisations in Stockport this may preclude this as a viable option.

4. Effective delivery of the new model of care		
4a. Scope of Services	🔴	Form could not sustainably deliver full in scope services and specifically will be unable to deliver Emergency Department services.
4b. Service User/Patient Choice	🟢	Service User / Patient Choice retained within Stockport.
4c. Transition Timeframes	🟡	Whilst the form can be easily set-up the transition and due diligence process is likely to be challenging and timely which could impact delivery of new model of care.
4d. Responsiveness	🟡	There may be lack of alignment between those services in scope and out of scope. Conflicting organisational priorities could adversley impact the outcome for patients and service users.
4e. Service User/Patient Experience	🟢	
4f. Alignment with other Strategies	🟡	This form is in line with the Greater Manchester integration strategy. However it is anticipated that there will be political and public opposition to non-public ownership.
5. Impact on wider health and care workforce		
5a. Terms and Conditions	🟡	This form allows flexibility regarding terms and conditions of service. However, whilst a Community Interest Company is aligned to a public sector ethos it is anticipated that staff TUPE to non-public sector organisation is unlikely to be supported by Trade Unions and Professional Bodies.
5b. Pensions	🟡	

3.5.1 Corporate Joint Venture: Community Interest Company Commentary

Building on the detailed appraisal set out above; outlined below are a series of summary conclusions set against the criteria.

3.5.2 Partnership Consensus

The following headline comments were raised by Provider partners:

- Ensuring democratic accountability and retaining public ownership were key for partners within Stockport.
- This option was felt to be financially high risk due to the nature of Corporate Joint Venture financial frameworks. In addition, one or more partners are unable or unwilling to bear financial risk.

3.5.3 Governance and Accountability Assessment

Overall Assessment: Possible but material risk to delivery

There are a number of key issues deemed 'possible but with a material risk to delivery' by provider organisations specifically relating to stakeholder influence, ownership and organisational sustainability:

- It is not anticipated that this model can be as democratically accountable as other forms which will pose an additional complexity for the Local Authority in delivering its statutory responsibilities
- Because of the scale and scope of the MCP, it is anticipated that there is likely to be potential political and public opposition to non-public sector ownership; and
- There is a risk that this vehicle will not be sustainable and able to respond to political/regulatory changes/challenges. In particular relating to the current financial context of the system and the ability of this form to hold financial risk due to the requirements of the Insolvency Act

3.5.4 Value for Money and Affordability Assessment

Overall Assessment: Not possible

All the financial criteria within the assessment for this option are deemed either 'not possible' or 'possible but with a material risk to delivery'. The key issues are:

- The ability of this form to manage financial risk and bear system deficit is a significant challenge due to the requirements of the Insolvency Act and the scale of the current system deficit. Parent company guarantees would be required to back the JV. It would be unlikely that current providers would be able to do this following due diligence
- The increased independence of the organisation puts a greater risk on legacy services across the health and social care system. This poses a significant risk to affordability and sustainability of those services which are not in scope to the proposed MCP; and
- The option is deemed to be financially higher risk due to the nature of Corporate Joint Venture financial frameworks. One or more Provider partners have also made it clear that they do not have the ability to bear financial risk

3.5.5 Enables GP Influence Assessment

Overall Assessment: Possible but material risk to delivery

Organisational governance can be developed to enable GP influence through representation at different levels within the organisation; however the level of GP control may be limited by both Foundation Trusts and the Council requesting or requiring a veto on the grounds that they are the principal providers of capital and financial risk bearer. Ultimately, the current financial position of Stockport NHS FT and Stockport MBC are likely to preclude this as a viable option for GP influence. This form can be built from the GP registered list.

3.5.6 Effective Delivery of the New Model of Care Assessment

Overall Assessment: Not possible

This form would not be able to sustainably deliver all services in scope as a result of the limitations of the financial and legal framework within which it would operate. It was also considered to be highly complicated by providers and the transition to this model could impact upon person and system level outcomes. There is also likely to be political and public opposition to non-public ownership.

3.5.7 Impact on Wider Health and Care Workforce Assessment

Overall Assessment: Possible but material risk to delivery

This form offers flexibility with terms and conditions and whilst as a Community Interest Company this would be aligned to public sector ethos, it is not expected to be widely supported by the workforce and Trade Unions since it would involve transferring services from public ownership.

3.5.8 Statement of Appraisal

The assessment of this option presented more sub criteria deemed ‘not possible’ or ‘possible but with a material risk’ to delivery than those deemed ‘possible and deliverable’. In addition to the legal and financial risks outlined above, the form could not sustainably deliver full in scope services and the level of GP control may be limited by organisations who are the principle providers of capital (FT and Council). The TUPE of staff to a non-public sector organisation is unlikely to be supported by trade unions and professional bodies and the form is also considered complicated from a governance perspective by all provider organisations. This option is **NOT RECOMMENDED**.

3.6 Assessment of option 5 - Limited Liability Partnership

Fig. 15. Detailed appraisal for option 5 – Limited Liability Partnership

Option 5 - GP Led Limited Liability Partnership		Assessment
1. Effective Governance and Accountability		
1a. Stakeholder Influence	🟡	Form can be easily established and structured to deliver MCP contract. In particular there are flexibilities on governance as there are no formal requirements in how such entities are governed. However it is not anticipated that this model can be as democratically accountable as other forms which will pose an additional complexity for the Local Authority in delivering its statutory responsibilities. A further consideration is that if the proportion of capital input dictated an individual provider's board representation this would not enable equitable representation and influence from all partners, in particular GP representation and influence.
1b. Professional Governance and Outcomes	🟢	Clear clinical and professional governance could be established within a single form
1c. Regulation	🟢	GP led LLP could be regulated within existing frameworks but would require clear governance arrangements to be put in place.
1d. Legal	🟡	There are potential legal implications for SMBC, who would not be able to participate in an LLP if the activity under consideration was with a view to profit (due to S95 Local Government Act 2003).
1e. Ownership	🟡	It is anticipated that there is likely to be potential political and public opposition to non-public sector ownership.
1f. Organisational Sustainability	🟡	There is a risk that this vehicle will not be sustainable and able to respond to political/regulatory changes/challenges. In particular relating to the current financial context of the system and the ability of this form to hold financial risk due to the requirements of the Insolvency Act.
1g. Branding	🟡	It would be possible to create a new brand however there is likely to be opposition to a new form which falls outside of public sector branding.
2. Affordability and Value for Money		
2a. Deficit Budget Setting	🔴	The ability of this form to manage financial risk and bear system deficit is a significant challenge due to requirements of the Insolvency Act and the scale of the current system deficit.
2b. TAX/ VAT/Insurance/ Procurement/Charging Implications	🟡	There is a VAT implication as NHS bodies which hold a sub contract from a non NHS body will not be able to recover VAT for contracted out services. This is likely to incur a cost to the system.
2c. Transition Costs	🟡	Transition costs are anticipated for example through the harmonisation of terms and conditions of service. In addition the cost of private capital may be higher than public capital if required to establish this form.
2d. Wider public sector/system pressures	🟡	Increased independence of the organisation puts a greater risk on legacy services across the health and social care system. This poses a significant risk to affordability and sustainability of those services not in scope.
2e. Risks and Benefits	🔴	Flexibilities to set gain share amongst members commensurate with distribution of financial risk. In addition one or more partners are unable or unwilling to bear financial risk.
3. Enables GP Influence		
3a. Practice Based Population	🟢	Can build from Registered GP list
3b. GP Leadership	🟢	The flexibilities associated with this governance arrangement mean that GPs can take-up roles throughout the organisation, including as: Directors, Stakeholders, Employees or a combination of these roles. As such this form offers the opportunity to maximise the GP voice, control and involvement in decision making and maximises the opportunity for members (e.g. GPs) to gain from delivering efficiencies. GP may assume financial risk (unless third party private capital is used) however private investors would most likely seek return and significant influence in return for investment.

4. Effective delivery of the new model of care		
4a. Scope of Services	🔴	Form could not sustainably deliver full in scope services and specifically will be unable to deliver Emergency Department services.
4b. Service User/Patient Choice	🟢	Service User / Patient Choice retained within Stockport.
4c. Transition Timeframes	🟡	Whilst the form can be easily set-up the transition and due diligence process is likely to be challenging and timely which could impact delivery of new model of care.
4d. Responsiveness	🟡	There may be lack of alignment between those services in scope and out of scope. Conflicting organisational priorities could adversley impact the outcome for patients and service users.
4e. Service User/Patient Experience	🟢	
4f. Alignment with other Strategies	🟡	This form is in line with the Greater Manchester integration strategy. However it is anticipated that there will be political and public opposition to non-public ownership.
5. Impact on wider health and care workforce		
5a. Terms and Conditions	🟡	This form allows flexibility regarding terms and conditions of service. However, staff TUPE to non-public sector organisation will be opposed by Trade Unions and Professional Bodies.
5b. Pensions	🟡	

3.6.1 Limited Liability Partnership Commentary

Building on the detailed appraisal set out above; outlined below are a series of summary conclusions set against the criteria.

3.6.2 Partnership Consensus

The following headline comments were raised by Provider partners:

- Democratic accountability and public ownership were key to partners within Stockport
- As with Option 4, this option was felt to be financially high risk due to the nature of LLP financial frameworks. In addition, one or more partners are unable or unwilling to bear financial risk; and
- This option presents significant opportunity for GP influence and leadership within this model

3.6.3 Governance and Accountability Assessment

Overall Assessment: Possible but material risk to delivery

There are a number of issues deemed as a 'possible but with a material risk to delivery' within this form relating specifically to stakeholder influence, legal considerations, ownership and organisational sustainability:

- The form would not be as democratically accountable as other forms bringing additional complexity for the Local Authority in delivering its statutory responsibilities
- SMBC would not be able to participate in an LLP if the activity under consideration was with a view to profit due to S95 Local Government Act 2003; and
- There is a risk that this vehicle will not be sustainable and able to respond to political/regulatory changes/challenges. In particular relating to the current financial context of the system and the ability of this form to hold financial risk due to the requirements of the Insolvency Act

3.6.4 Value for Money and Affordability Assessment

Overall Assessment: Not possible

All of the financial criteria are deemed either 'not possible' or 'possible but with a material risk' to delivery. The key issues which render this option 'not possible' are:

- The ability of this form to manage financial risk and bear system deficit is a significant challenge due to requirements of the Insolvency Act and the scale of the current system deficit
- There is a VAT implication as NHS bodies which hold a sub contract from a non NHS body will not be able to recover VAT for contracted out services. This is likely to incur a cost to the system; and
- The option is deemed to be financially higher risk due to the nature of LLP financial frameworks. One or more Provider partners have also made it clear that they do not have the ability to bear financial risk

3.6.5 Enables GP Influence Assessment

Overall Assessment: Possible and Deliverable

The governance framework for this form is flexible enough to maximise GP influence and involvement in decision making. GPs will however have to assume financial risk unless an alternative or third party private capital is used. This form can be built from the GP registered list.

3.6.6 Effective Delivery of the New Model of Care Assessment

Overall Assessment: Not possible

This form would not be able to sustainably deliver all services in scope as a result of the limitations of the financial and legal framework within which it would operate. It was also considered to be highly complicated by providers and the transition to this model could impact upon person and system level outcomes. There is also likely to be political and public opposition to non-public ownership.

3.6.7 Impact on Wider Health and Care Workforce Assessment

Overall Assessment: Possible but material risk to delivery

This form offers flexibility with terms and conditions however it is anticipated that the TUPE to a non-public sector organisation will be **strongly opposed** by Trade Unions and Professional Bodies.

3.6.8 Statement of Appraisal

The assessment of this option presented more sub criteria deemed 'not possible' or 'possible but with a material risk to delivery' than those deemed 'possible and deliverable'. In addition to the legal and financial risks outlined above, the form could not sustainably deliver full in scope services and the level of GP control would be limited by organisations who are principle providers of capital (Private Sector). It is unlikely that GP's would be prepared to bear the significant financial risks associated with this option. In addition, the prospect of staff being TUPE transferred to a non-public sector organisation is highly likely to be strongly opposed by trade unions and professional bodies. This option is **NOT RECOMMENDED**

A visual summary of the outcome of the assessment for each option is shown in Fig. 16. below.

Fig. 16. Summary table of hurdle criteria assessment

- Not possible (legal or procurement framework does not allow)
- Possible but a material risk to delivery
- Possible and deliverable

	Option1 Contractual Alliance	Option2 New Neighbourhood Led ACO	Option3 Lead Provider	Option4 Corporate Joint Venture	Option5 GP Led Limited Liability Partnership
1. Effective Governance and Accountability					
1a. Stakeholder Influence	🟢	🟡	🔴	🟡	🟡
1b. Professional Governance and Outcomes	🟢	🟢	🟢	🟢	🟢
1c. Regulation	🟢	🟢	🟢	🟡	🟢
1d. Legal	🔴	🟢	🟢	🟢	🟡
1e. Ownership	🟢	🟢	🟢	🟡	🟡
1f. Organisational Sustainability	🟡	🟢	🟢	🟡	🟡
1g. Branding	🟢	🟢	🟡	🟡	🟡
2. Affordability and Value for Money					
2a. Deficit Budget Setting	🟢	🟢	🟡	🔴	🔴
2b. TAX/ VAT/Insurance/ Procurement/Charging Implications	🟢	🟢	🟢	🟡	🟡
2c. Transition Costs	🟢	🟢	🟢	🟡	🟡
2d. Wider public sector/system pressures	🟢	🟢	🟡	🟡	🟡
2e. Risks and Benefits	🟡	🟢	🟡	🔴	🔴
3. Enables GP Influence					
3a. Practice Based Population	🟢	🟢	🟢	🟢	🟢
3b. GP Leadership	🟢	🟢	🟢	🟡	🟢
4. Effective delivery of the new model of care					
4a. Scope of Services	🟢	🟢	🟢	🔴	🔴
4b. Service User/Patient Choice	🟢	🟢	🟢	🟢	🟢
4c. Transition Timeframes	🟢	🟢	🟢	🟡	🟡
4d. Responsiveness	🟡	🟢	🟡	🟡	🟡
4e. Service User/Patient Experience	🟢	🟢	🟢	🟢	🟢
4f. Alignment with other Strategies	🟡	🟢	🟢	🟡	🟡
5. Impact on wider health and care workforce					
5a. Terms and Conditions	🟢	🟢	🟢	🟡	🟡
5b. Pensions	🟢	🟢	🟢	🟡	🟡

🔴 Not possible	1	0	1	3	3
🟡 Possible but a material risk to delivery	4	1	5	14	13
🟢 Possible and deliverable	17	21	16	5	6

Section 4 - Support Services

4.1 Introduction and Background

Support Services are critical to enabling operational services and supporting the implementation of the new Integrated Service Delivery model and MCP within Stockport. As the two largest employers in Stockport, Stockport MBC and Stockport NHS Foundation Trust (FT) both retain significant public support services, with a shared value of approximately £49m, employing around 1,225 Whole Time Equivalents (WTE). Other Stockport Together partners also draw on important support services from a variety of sources. If Stockport Together is to be a success, the scale and ambition for transformation must apply as much to local support services as to those working directly with patients and service users.

Work to date, through the Enablers workstream within Stockport Together, has created an ethos of collaborative working across support services and delivered important early value including; shared networks and wi-fi, integrated estate plans, a robust information sharing framework, an integrated programme management office, and a joint programme of workforce engagement and development. This work and the strong relationships forged through it provide the foundation for rapid further integration of support services.

As a key element of the MCP Form options appraisal, this section therefore presents high level assessment of the potential options for support services within Stockport and recommends further detailed work to establish how best to secure additional benefits through closer working. The headline review that informs this assessment has focussed initially on Stockport MBC and Stockport NHS FT support services, but has been conducted with an awareness of the potential for further engagement with other partners including Viaduct and Stockport CCG in future.

The high-level assessment addressed the following issues:

- Whether there were obvious benefits to any given contracting approach across Stockport Together partners
- The wider benefits of support service integration
- The extent to which these opportunities and benefits might be dependent upon or aligned to the development of any particular MCP form; and
- The principles that should inform further support service integration

The assessment makes clear that significant further integration of support services is both practical and viable, could take a wide-range of forms, and would have significant benefits for Stockport MBC, Stockport NHS FT and the wider health and care economy.

4.2 Initial Assessment

4.2.1 Contracting approach

Our initial consideration is the contracting or partnership route through which the resulting analysis, design and implementation programme would ‘flow’. In high-level terms the options are:

- Procurement based exercise to establish packages of out-sourced support
- Public-to-public contracting arrangement; or
- Formal partnership approach between respective public sector organisations

Having reviewed the respective merits of the approaches above, our working assumption for the remainder of this assessment is that options b) or c) above would be preferable for following reasons:

- **Timing** – In order to effectively support the implementation of the new Integrated Delivery Model, the transformation and integration of support services needs to take place ahead of wide spread operational reform. This will enable support services to best effectively support transformation. **A public-to-public contract or formal partnership removes the need for an extensive process under OJEU regulations which would result in six to nine months delay** prior to substantive decisions being made regarding the future form, and before any new model will be in place to support the MCP 'on the ground'

- **Local Employment** – A high percentage of employees within Stockport NHS FT and Stockport MBC are residents of Stockport. A public-to-public partnership ensures good local jobs remain available, supporting our shared ambition to promote independent and sustainable communities

- **Shared ethos and culture** – Stockport NHS FT and Stockport MBC are both underpinned by a strong public service ethos. Joint working, workforce reform and cultural integration should be more easily achieved than with a private sector partner where profit and shareholder value would potentially provide constraints, points of tension and result in additional costs

- **Flexibility of regulation** – section 12(7) of the Public Contract Regulations 2015 would be an efficient way to manage the integration and/or contracting of support services between the Council and the FT

- **Stakeholder engagement** – internal communications and engagement with staff, unions and our respective management communities should be an early consideration, in concert with regional and national dialogue with NHSE/NHSI. A public-to-public rather than a public-to-private model is likely to be more reassuring to key local stakeholders including our joint workforce, residents, clinicians and Elected Councillors; thereby reducing any potential opposition to integration

Given the complexity and pace of the programme and partnership working currently and anticipated over the next 2-3 years, it is preferable that Providers within Stockport retain closer control and influence over support services to ensure they continue to develop to support transformation and are 'designed in' as part of the new Integrated Delivery Model.

It is clear that a public-to-public approach does not preclude the consideration of any market opportunities in the future, or opportunities to align support services to other public service providers (either for support services in-whole or in-part). The consideration of alternative delivery or contracting models for specific services where appropriate would form part of the second, more detailed, phase of this work.

At this stage, and reflecting the strong case set out above, it is proposed to seek an integration of support services between Stockport MBC and Stockport NHS FT in the first instance, whilst making clear that:

- Partial integration can be either fixed (for certain service areas) or a transitionary stage in the process depending on the agreed journey of integration; and
- Partial integration between Stockport NHS FT and Stockport MBC does not preclude other partners (e.g. Viaduct) engaging in an integrated model on all or some of the support services in question

This approach will simultaneously promote greater joint working between these two strategic organisations, meet the pace of transformation, enable direct influence over the identification the early positioning of and reducing overall costs through economies of scale, whilst retaining a vital economic footprint in the borough.

4.2.2 Benefits of Support Service Integration

The benefits associated with integration in individual service areas are diverse, ranging from the creation of efficiency savings to improving joint working between Partners. Which services are integrated at what phase in the transformation process will depend upon Stockport's priorities for change. Overarching benefits that have been identified from a Stockport-led integration of support services include:

- The local health and care economy retaining direct influence over support service quality and model, so that it can be adapted to meet future changes
- Greater local resilience through integration, with shared support services that can efficiently flex and respond to changing demands and priorities
- Value for Money through identifying cross-organisational efficiencies and economies of scale
- Integration challenges cultural norms through sharing learning, skills and experience across the entirety of both organisations
- A clear focus on meeting immediate transformational requirements by reducing organisational barriers and therefore ensuring pace and responsive support; and
- Retaining a strong local employment offer with good careers in and across Stockport public services, enabling Stockport to recruit and retain talent thereby driving up quality and improving outcomes for local people

Clearly, in addition to the benefits of integration, there are associated risks, including:

- Support service changes affecting the pace of transformation by diverting resources and focus from operational transformation
- Lack of alignment between support service and operational priorities resulting in support services which don't meet the needs of Stockport's MCP and relevant partner organisations
- Ensuring different regulatory, governance and operating frameworks are adhered to within an integrated environment (including addressing any risks of conflict of interest); and
- Workforce instability and uncertainty within support services across partners risks not only progress and pace but also workforce buy-in to change and implementing a shared ethos

These risks will need to be developed further and considered alongside a more detailed appraisal of support service opportunities.

4.2.3 MCP Form and Support Services

Regardless of MCP organisational form, support services integration is a feasible aspiration (be it partially or fully integrated) and there are significant merits in aligning support services to drive efficiency and quality of these functions.

A key determining factor with realising the benefits (including efficiencies) ascribed in the section above, however, will be the degree of integration within operational services. Any MCP form which is able to integrate more fully and quickly will provide the enabling conditions and relationships to drive common policies, integrated platforms and a shared ethos, and ultimately deliver an increased level of efficiencies.

4.2.4 Suggested Support Service Design Principles

A clear set of design principles will be central to designing support services that meet the requirements and ambition within Stockport. A proposed set of design principles, based on the points outlined earlier, are set out below for consideration, they emphasise:

- **Public Ownership and Culture -** Support services should be underpinned by a public service ethos and should be able to work more collaboratively/trustingly than they could with a private sector partner where profit and shareholder value would potentially provide constraints, points of tension and result in additional costs. In addition, retaining local people in jobs within Stockport is a fundamental value and supports the local economy not simply through employment but also the wider economic footprint of the local public sector (for example infrastructure, sub-contractors and 're-spend' within Stockport)

- **Focussed on People and Place** - A modern support offer needs to respond to public service reform principles. They must wrap themselves around – and facilitate expertise in – the people that use services and the places in which they live. Local knowledge and relationships are vital

- **Resilience through Integration and Economies of Scale -** Support services have undergone significant change and are already working within a reduced financial envelope. Through integrating support services we can achieve economies of scale, efficiencies and resilience across the Health and Social Care economy

- **Inclusivity -** Our starting point will be from the 'art of the possible' with all services across the Stockport NHS FT and Stockport MBC in scope of transformation

- **Transformational** - Stockport's support services should be at the cutting edge of transformation and innovation and at the forefront of change in Stockport. This will ensure a responsive and efficient model is in place to support the implementation of the Integrated Care Delivery model which can adapt as necessary to the changing national and local landscape within support services

- **Alignment with Strategies on Tactical and Operational issues within the Health and Social Care Economy** - The design of support services needs to align with any ambition and strategy outlined in the new Integrated Service Delivery Model and needs to be capable of flexing and responding to future strategic, tactical and operational change quickly, effectively and with the right skilled workforce

- **Open and Timely Engagement -** Transparent engagement within the design of an integrated support service is key. This will be cross-cutting and include timely communications and engagement with workforce, including Trade Unions and Professional Bodies, operational leads, organisational governance, Elected Members and relevant regulatory or government representatives (e.g. NHS Improvement, Department of Health, NHS England and Local Government Association)

- **Pace -** Stockport Together is ambitious and the pace of change is rapid. To ensure support services meet this pace it is proposed that a public sector partnership or public-to-public transfer of services is the preferred model. The proposal is that the contracting route in this instance would be through section 12(7) of the Public Contract Regulations 2015

4.3 Conclusion, recommendations and next steps for Support Services

The conclusions of this initial assessment highlight that there is an opportunity to ensure better resilience and improved economy and efficiency across Stockport Together's support services through a more formal programme of integration between partners, specifically at this stage Stockport NHS FT and Stockport MBC. Building on recent experience of delivering a recurrent £8m annual saving in support services through internal integration, and as the current Stockport Together lead for Enablers, it is proposed that Stockport Council lead this work in partnership with the FT.

This work must progress at pace to ensure the right support is available to critical areas during a period of significant transformation. To this extent it will remain aligned to and take account of the wider development of the MCP organisational form but commence separately to ensure critical transformation timeframes can be met.

4.3.1 Recommendation for Support Services

Agreement is therefore sought to:

- Develop a specification for a structured programme that results in an option for an integrated support services
- Adopt the design principles and next steps identified above to inform this programme
- To focus in the first instance upon support services in Stockport NHS FT and Stockport MBC
- Adopt a public sector led arrangement either through a partnership or public to public transfer in the first instance to enable effective support services to meet critical transformation requirements in the development of the care model; and
- Stockport MBC to work with the FT to bring back a detailed report for consideration by the Stockport Together Board and appropriate organisational governance along with a proposed approach to programme investment, governance, accountability arrangements and requisite third-party support

4.3.2 Next steps for Support Services

Further work will be required to develop a robust evidence base and implementation plan for further integration. This will include; an appraisal of support service models, a review of organisational metrics, consideration of variance and identification of any 'quick win' opportunities and a formal due diligence process.

As part of this work an appraisal of different options, in line with the approach adopted for identifying the MCP forms set out above, will be followed. This will involve a set of options appraisal criteria which will be applied to different variations of form. These are outlined in *Fig. 17.* on the next page.

Fig. 17. Proposed Support Service Appraisal Criteria

Value for Money (VfM)	Governance and Influence	Transformational Opportunities	Impact on Workforce
The degree to which the option delivers cashable savings, net of investment required (considering time and complexity to derive benefit).	Enables clear governance and stakeholder influence	Enables Flexibility, Scalability and Innovation	The degree to which the model is resilient and where possible seeks to secure local jobs
Enables resilient support services	Enables alignment with Strategic, Tactical and Operational priorities and is able to adapt to future change	The degree to which the option meets Service Delivery Outcomes	

Alongside the above, as GM devolution within Health and Social Care develops further, particularly in areas relating to support services, this approach will be adapted to ensure a wider alignment with sub-regional priorities and approach.

Based on this process, a set of options and recommendations for change will be developed. This will be used to draft an initial roadmap of what the change process might look like and to indicate the timeline for reform. The pace and phasing of support service integration could vary according to the commonality of services and systems across the Council and FT. The complexity of, and degree of variability across partner functions, will determine the extent to which delivery models are aligned and complementary and ultimately the approach to and pace of transition.

Section 5 - Conclusion and Recommendation

The purpose of the options appraisal report is to provide members of each Provider partner organisation with a recommendation regarding the preferred organisational form under which the MCP in Stockport is established.

5.1 Outcome of the options appraisal

The outcome has been constructed from the feedback from engagement with Senior Leadership Teams within each Provider. This has informed the application of the hurdle criteria (outlined in section 3) to the sub-criteria for all five options.

Three options are recommended to be immediately discounted based on the application of the assessment criteria (due to the number of 'not possible' and 'possible but with a material risk to delivery'). These were:

- Option 3 - Lead Provider (Host): 1 'not possible' and 5 'possible but with a material risk to delivery'
- Option 4 - Corporate Joint Venture: Community Interest Company: 3 'not possible' and 14 'possible but with a material risk to delivery'
- Option 5 - Limited Liability Partnership: 3 'not possible' and 13 'possible but with a material risk to delivery'

Option 1 - Contractual Alliance. Whilst a contractual alliance is a legal accountable framework, the local commissioners have made it clear through the current procurement process that this would only be acceptable on a transitional basis towards a single organisational form. It is recommended that this option is also discounted.

The leaves **only one option** where a consensus was reached between the Senior Leadership of all Providers that was deemed 'possible and deliverable', this is:

- **Option 2 - A New Neighbourhood Led Accountable Care Trust**

Whilst consensus was reached, this option will require subsequent agreement between Providers regarding achieving an appropriate balance of stakeholder influence within an FT governance framework. It is anticipated that the Final Business Case (FBC) stage will enable debate and consideration of this to be worked through to a resolution that is agreeable to all Providers. It should be noted that if all Providers approve the recommendation of this options appraisal, this only commits to the very detailed work up of an FBC (and associated costs).

It is also important to stress that the completion of the FBC is part of the much larger procurement and regulatory process described in section 1, the timescales for which have yet to be confirmed. Once approved by Provider governance processes, the FBC would therefore also be subject to the outcome of the Joint Commissioning Procurement process and would require regulatory approval by NHS England and NHS Improvement

A breakdown of the hurdle criteria assessment is show in *Fig. 18.* below for transparency.

Fig. 18. Outcome of the hurdle criteria assessment

Hurdle Criteria Assessment			
	Not possible	Possible but a material risk to delivery	Possible and deliverable
Option 1 Contractual Alliance	1	4	17
Option 2 New Neighbourhood Led ACT	0	1	21
Option 3 Lead Provider	1	5	16
Option 4 Corporate Joint Venture	3	14	5
Option 5 GP Led Limited Liability Partnership	3	13	6

It is the recommendation of this options appraisal that the option to form A New Neighbourhood Led Accountable Care Trust should be considered by all Providers for approval to progress to be fully worked up in detail to a Final Business Case (FBC) following legal agreements, regulatory and financial due diligence.

In addition, as outlined in section 4 in relation to support services, it is recommended that Stockport MBC and Stockport NHS FT:

- Develop a specification for a structured programme that results in an option for an integrated support services
- Adopt the design principles and next steps identified in section 4 to inform this programme
- Focus in the first instance upon support services in Stockport NHS FT and Stockport MBC
- Adopt a public sector led arrangement either through a partnership or public to public transfer in the first instance to enable effective support services to meet critical transformation requirements in the development of the care model; and
- Develop a detailed report for consideration by the Stockport Together Board and appropriate organisational governance along with a proposed approach to programme investment, governance, accountability arrangements and requisite third-party support

Section 6 – Next Steps

6.1 Next steps

The immediate next steps are for this options appraisal report to be considered by each Provider organisation with a view that it is formally approved at the designated approval meetings – see *Fig.19.* below.

Fig. 19. Sharing of Options Appraisal Paper and final approval

	Stockport FT	Stockport MBC	Viaduct Health	Pennine Care FT
Organisational Governance	**19 October** Council of Governors	**25 October** Health & Wellbeing Scrutiny **31 October** Adult Care Scrutiny **1 November** Corporate Resources Scrutiny	**18 October** GP Engagement Event **26 October** Board Meeting	**26 October** Board of Directors
Formal Approval Meeting	**24 November** Board of Directors (Public)	**15 November** Council Executive (Public)	**23 November** Board meeting	**30 November** Board of Directors (Public)

The existing Providers agreed to adopt the principle of using one set of joint legal advice to develop this options appraisal as this is a joint provider view on the options and no provider is bound by the recommendations until Final Business Case.

From this stage, each Provider will need to take a view as to whether they require independent legal advice. All Providers reserve the right however, to take separate legal advice at any point should this be required in their view.

It is important to stress that the completion of the FBC is part of the much larger procurement and regulatory process described in section 1, the timescales for which have yet to be confirmed. Once approved by Provider governance processes, the FBC would therefore also be subject to the outcome of the Joint Commissioning Procurement process and would require regulatory approval by NHS England and NHS Improvement

6.2 Development of a Final Business Case (FBC)

This undertakes the detailed analysis of the recommended option which would include legal agreements, financial risk shares, and regulatory approval from the NHS including full due diligence. A full plan including resource requirements and a timetable will need to be agreed following approval through each Provider's organisational governance.

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APPENDICES

Appendix.1 – Equality Impact Assessment

Appendix.1 - Equality Impact Assessment

1.1 Introduction

This Equality Impact Assessment (EIA) assesses the evidence for and potential impact of the developing the Multi-Speciality Community Provider on the public and staff.

Stockport has been selected as one of the NHS's Vanguard sites, responsive for developing and testing a new model of care based on the MCP model set out in the NHS's Five Year Forward View.

This analysis will use research, data, and consultation feedback to understand the impact or potential impact of the proposed model on groups given protection under the Equality Act 2010. The analysis aims to capture positive impact and identify any negative effects or discrimination arising from the new model of care, ensuring it is in line with the Public Sector Equality Duty of the Equality Act 2010.

This assessment is currently in draft form which reflects the current stage of the MCP form process. This EIA will be updated throughout the lifecycle of the form appraisal and thorough due diligence process and will within it include the identification of further work required, any emerging impacts, and the mitigation of any potential negative impacts identified.

Please note, this EIA is aligned to an overarching EIA which has been produced for Stockport Together and does not seek to duplicate this assessment. In addition, it is not within the scope of this EIA to consider any changes to services as they designed and implemented (e.g. intermediate tier, integrated neighbourhood teams). In these instances specific equality impact assessments will be undertaken.

1.2 About the Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- Tackle prejudice, and
- Promote understanding

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

- To consider whether the policy will help eliminate unlawful discrimination, harassment and victimisation
- To consider whether the policy will advance equality of opportunity between people who share a protected characteristic and those who do not
- To consider whether the policy will foster good relations between people who share a protected characteristic and those who do not; and
- To inform the development of the proposed policy

1.3 Stockport Together

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Health) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough.

It is recognised that over the coming years, health and social care will be subject to increasing demand from an ageing population, combined with a financial position that isn't going to increase in line with this demand. The Stockport Together programme seeks to address these challenges.

As noted already, Stockport has been selected as one of the NHS's Vanguard sites, responsible for developing and testing a new model of care based on the Multi-Speciality Community Provider, or MCP, model set out in the NHS's Five Year Forward View.

The five organisations have developed a strategic plan for the borough with professionals and leaders across Stockport. The programme will implement an integrated service solution via four workstreams:

- Acute Interface
- Core Neighbourhoods
- Healthy Communities
- Boroughwide Services

As noted above, each workstream will complete an Equality Impact Assessment (or assessments depending on the breadth of changes proposed) and the output of these will be considered separately and in line with the overarching Stockport Together EIA.

1.4 MCP

First described in the NHS Five year Forward View, the MCP is a new type of integrated place based provider serving the whole population whose defining feature is the registered list of the participating GP Practices. It is intended to combine the delivery of primary care, community-based health and social care services and the provision of some services currently based in hospitals such as the Emergency Department, diagnostics and out-patients. The building blocks of an MCP are the 'care hubs' of integrated neighbourhood teams with each neighbourhood typically serving a community of around 30-50,000 people.

Stockport already has in place a pooled budget which is built on existing Section 75 arrangements and forms the foundation of integrated provision and commissioning. The four Providers have also put in place a signed memorandum of understanding (MOU) to regulate their joint working and have established a Shadow Provider Board as the focal point for these arrangements. Stockport's Integrated Commissioning Board have formally instigated a procurement process for an MCP, as part of this process, the four providers have been asked to identify their preferred option in terms of form for the proposed new entity.

The Shadow Provider Board has adopted a two stage approach to this process. Firstly, the identification of a preferred option through an options appraisal exercise which will be completed by the end of November 2016 following appropriate organisational consideration. This would then be followed by a Final Business Case incorporating a detailed analysis and due diligence of the preferred option.

This EIA will accompany the decision making documentation throughout both stages of this process. In particular it is anticipated that a thorough analysis will be required during the second phase of this process.

2. Assessing the impact of Stockport Together on the community

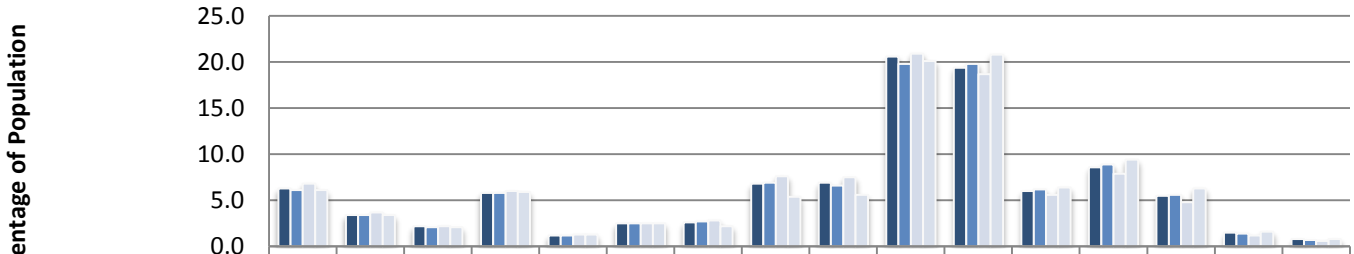
2.1 Stockport Community data

The total population of Stockport is currently 286,775 (Mid-year Population Estimates, 2014), a figure which has been relatively stable over the last 10 years. The information below details the population data available in relation to equality and diversity in Stockport. This data has been used alongside feedback from local community groups to consider how the priorities and actions outlined in our plan are likely to impact on different groups.

Stockport has an older age profile than the national average, with comparatively high numbers of residents aged 45-59 and low numbers of 18-44 year olds. The median age at the 2011 census was 41 (up from 39 ten years ago)

and recent mid-year population estimates identify that 19.4% of the population is aged 65 or over, which is higher than the national average.

Population by age group



	Age 0 to 4	Age 5 to 7	Age 8 to 9	Age 10 to 14	Age 15	Age 16 to 17	Age 18 to 19	Age 20 to 24	Age 25 to 29	Age 30 to 44	Age 45 to 59	Age 60 to 64	Age 65 to 74	Age 75 to 84	Age 85 to 89	Age 90 and over
ENGLAND	6.3	3.4	2.2	5.8	1.2	2.5	2.6	6.8	6.9	20.6	19.4	6.0	8.6	5.5	1.5	0.8
NORTH WEST	6.1	3.4	2.1	5.8	1.2	2.5	2.7	6.9	6.6	19.8	19.8	6.2	8.9	5.6	1.4	0.7
Greater Manchester	6.8	3.7	2.2	6.0	1.3	2.5	2.8	7.6	7.5	20.9	18.7	5.6	7.9	4.8	1.2	0.6
Stockport	6.1	3.4	2.1	5.9	1.3	2.5	2.2	5.4	5.6	20.1	20.8	6.4	9.4	6.3	1.6	0.8

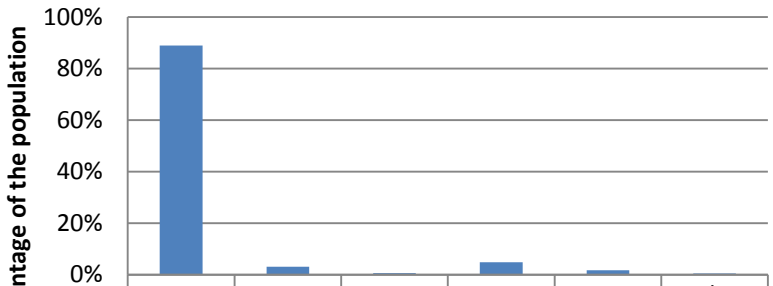
18.4% of Stockport residents are living with a long-term illness or disability. 8 of Stockport's 21 wards have levels of LLTIs above the national average, including all of Stockport's Priority 1 areas (those with the highest levels of deprivation). 8.6% of the population say their long-term condition or disability has a significant limiting impact on their daily activities.

11.3% of the population would describe themselves as unpaid carers. 2.5% provide 50 or more hours of unpaid care a week.

Stockport's birth rate has increased steadily since 2003 - over 3,400 babies were born to Stockport residents in 2008. Birth rates are higher among Stockport's ethnic minority groups and in areas of deprivation.

Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 census. If white ethnic minorities are included, such as Irish, Polish and traveller populations, this percentage rises to 11%. Areas to the west of the borough have the highest proportion of ethnic diversity – particularly among younger populations.

Ethnicity in Stockport



	White British	Other White	Black	Asian	Mixed Race	Other Ethnicity
Series1	89%	3.10%	0.70%	4.90%	1.80%	0.60%

The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. 25.1% of Stockport residents have no stated religion (up from 14.2% at the last census), which is in line with the national average. Stockport's second largest religion is Islam, which makes up 3.3% of the population - this is well below the national average of 5%, but the local figure has almost doubled since the last census.

Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Life expectancy in Stockport is higher for women at 83 years and 79.7 years for men.

There is currently no data on local trans-gender residents.

There is a lack of reliable data available regarding the profile of the LGBT community in Stockport. The government estimates that between 5% and 7% of the UK population is LGB, which would equate to 14-20,000 people in the borough.

2.2 Implications for the Community and Service Users

Any change in organisational form for the MCP will have a degree of impact on the community and service users. However it is anticipated that by and large these will be as a result of the design and implementation of the new models of care delivered through specific workstreams and therefore are out of scope of this specific EIA.

However, the preferred form will absolutely have an impact on the efficacy of implementation in terms of pace and level of integration. This is reflected by the inclusion of a dedicated criteria (and sub-criterion) within the options appraisal covering the 'Effective Delivery of the New Model of Care' to ensure it is effectively considered at this initial options appraisal stage.

Whilst it is not possible at this stage in the process to determine the scale or type of specific implications by equality group, once a preferred form is identified and approval reached to proceed with a Final Business Case for this option a thorough assessment of the impact on the community and service users will be required in line with analysis, due diligence and assessment of proceeding within this form.

Ongoing engagement (and if required formal consultation) with the public and patient and service user representatives will be critical during this period.

3. Assessing the impact of Stockport Together on the workforce

The traditional divide between primary care, community services, mental health, social care, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. Any change in organisational form is intended to support the new Integrated Delivery model in integrating teams from across different organisations and professional backgrounds. This will presents more than just a structural change – an MCP requires a major cultural shift to a new way of working, centred round prevention and empowerment of service users and delivering significant efficiencies to sustain high quality services into the future.

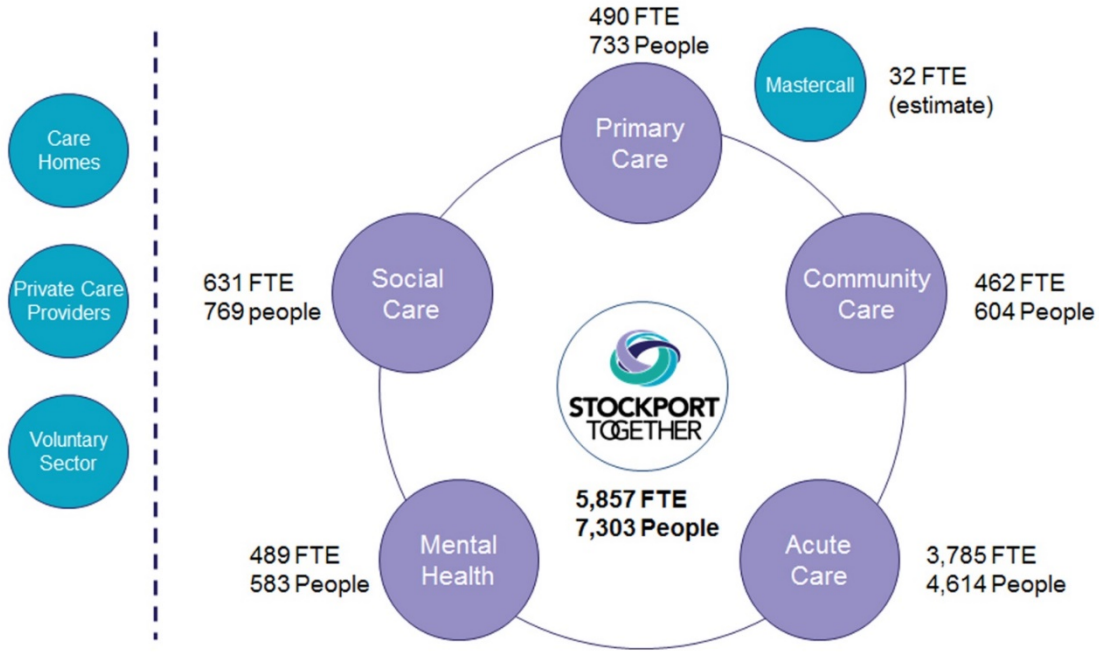
3.1 Workforce Baseline data

Health and Social Care in Stockport is overseen by a single Health & Wellbeing Board, given Stockport's geographic footprint which combines a coterminous Clinical Commissioning Group and Local Authority. Services are provided by one local acute hospital, which also runs our Community services; a main mental health provider,

1 ambulance service provider, 47 GP Practices, working towards developing a single primary care Federation model and one out-of-hours GP service.

Services work closely with a range of third sector providers and 64 local care homes. However, this baseline and strategy focuses on the 7,303 staff (5,875 full-time equivalents) directly employed in the above health and social care services.

Diagram.1 Our Combined Workforce



The vast majority of staff across health and social care in Stockport are employed by Stockport NHS Foundation Trust - 72.51% of full-time equivalents. This combines the 64.62% of employees working in the Hospital with the 7.89% of staff in Community Services.

Adult Social Care and Public Health make up the next biggest component of the workforce – 10.77%, followed by primary care (8.37%) and mental health (8.35%).

3.2 Workforce Profile

The following section describes the trends highlighted across the workforce profiles.

3.2.1 Full time/part time split

Current structures reveal variation in working patterns across the different parts of the system. Primary Care has particularly high levels of part-time working. Staff working in social care are much more likely to work full-time.

3.2.2 Gender

Traditionally, public services have attracted more women than men. In Stockport, the modal employee is a white woman in her 50s who is Christian, heterosexual and has no disabilities

This varies across sectors and roles, though the overarching trend is the same in each service. Community services have the least male employees - just 9% of full-time equivalents. The gender differential is least stark in social care, but even here men make up just a quarter of the workforce.

3.2.3 Ethnicity

Primary Care has the most ethnic diversity, the least being in community services, where 94.43 % of employees are white.

Within the sectors, ethnic diversity varies according to roles. In acute services, there is more ethnic diversity among medical and estates teams. In primary care, it is GPs who provide the most ethnic diversity to the overall workforce makeup.

3.2.4 Age

The most prominent feature of the workforce is its age profile. The majority of employees across the system are in their fifties. Social care has the oldest age profile of all sectors, the youngest being in hospital services.

A high proportion of the workforce is already in their fifties and therefore more likely to retire in the coming years:

- 54% of community staff
- 50% of social care staff
- 47% of primary care staff
- 41% of mental health staff
- 38% of acute staff

3.2.5 Sexual Orientation

Declaration of sexual orientation amongst the workforce is low and as such work to develop a consistent understanding of this across the Health and Social Care economy is required. Present data shows a significant proportion of the workforce as 'prefer not to state' and of those that have, the largest proportion have identified themselves as Heterosexual / Straight. Further data analysis will be undertaken to understand this protected group in Stockport.

3.2.6 Religion or Belief

The largest religion identified across the workforce is Christianity, for example within Community, Acute and Mental Health between 46 – 52% of the workforce identify themselves as Christian. This is much lower within Social Care (10%) and isn't currently known within Primary Care. As with 'Sexual Orientation' there are large numbers of the workforce who are identified as 'not declared'. Further data analysis will be required for these protected characteristics to produce a consistent understanding across Stockport's Health and Social Care economy.

3.2.7 Marriage/Civil Partnership, Gender Reassignment, Pregnancy and Maternity

Further data analysis will be required for these protected characteristics to produce a consistent understanding across Stockport's Health and Social Care economy. Consideration will be undertaken ahead of the next iteration of this Equality Impact Assessment as to how the impact on these groups can be understood.

3.3 Implications for the Workforce

Any change in organisational form for the MCP will have a degree of impact on the workforce, be it cultural or structural change.

It is anticipated that changes could affect staff in the following ways:

- Where they are located
- Team composition
- Training and workforce culture
- Where and by whom they are employed; and
- Job roles and responsibilities

It is not possible at this stage in the process to determine the scale or type of specific implications by equality group, however once a preferred form is identified and approval reached to proceed with a Final Business Case for this option a thorough assessment of the impact on the workforce will be required in line with analysis, due diligence and assessment of proceeding within this form.

Ongoing engagement (and if required formal consultation) with Trade Unions, Professional Bodies and the workforce itself will be critical during this period.

4. Recommendations and measures

This section will be updated in line the process outlined by the Provider Board for determining and agreeing MCP form. Further analysis and consultation will be required as a preferred form is identified.

Specific recommendations at this stage therefore are:

- To conduct further data analysis based upon the areas identified above;
- To ensure appropriate engagement or consultation (in line with the identification of a preferred organisational form) with staff and public to enable decision makers to identify any specific implications and to mitigate these where necessary; AND
- To continue to update this EIA throughout the lifecycle of this process.

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