Outline business case:
Adult social care alternative delivery model

Contents

1. Executive summary

Adult social care (ASC) services across the country face unprecedented pressures from the need to make budget savings, combined with growing demand, the requirements of the Care Act 2014 and rising expectations of service users. In order to meet this challenge at the necessary scale and pace, the way ASC is delivered in Barnet needs to be radically redesigned.

The Adults and Safeguarding Committee approved the approach to a proposed new operating model for ASC in November 2015. This document draws out the proposed new operating model and the changes required to implement it; and presents the findings from the second phase of this project: identifying the best alternative delivery model (ADM) through which to deliver the proposed new operating model.

The scope of the ADM includes the core activities carried out by ASC practitioners, and other activities that are closely linked to and support delivery of these core activities. The range of care services that practitioners help people to identify and access are outside of the ADM scope.

The appraisal of the ADM options was informed by activities including informal market engagement; workshops and meetings with stakeholder groups; research into ADMs and development of a proposition for a reformed in-house service.

The ADM options under consideration are:

Reforming and delivering the service in-house. The in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. A transformation programme would be undertaken to implement the new operating model and ensure the continued financial and operational sustainability of the service. Stakeholders acknowledged this option as a tried-and-tested model that was known to be an effective way to support people and keep them safe. However, some staff thought the necessary changes could not be made through an in-house service. Some service users and carers agreed: they thought that it would be too difficult to "turn the service around" under this model.

Sharing services with public sector partner(s) such as local NHS organisations and/or other London Boroughs. The Council would join up with one or more local NHS organisations to deliver integrated health and social care services. A single organisation would be responsible for the delivery of local health services and ASC services. This shared service could also include another local authority partner. Stakeholders saw the potential of a shared service to improve and accelerate health and social care integration and provide what they described as a more "holistic" service. However, they also expressed concern that a NHS organisation would be the much larger partner and therefore would "dominate" the partnership.

A partnership outside the public sector. This option could be implemented as an outsourcing arrangement, where an external provider delivers the services for the Council, or a joint venture (JV), where a JV company is created, jointly owned by the Council and an external provider. Some staff felt that they might have greater "freedom" from Council policies and procedures if they worked within a private sector organisation. However, other staff were concerned that a private sector organisation would not have a strong public service ethos and would be less focused upon meeting the needs of individual service users and carers. Service users questioned whether it would be more difficult for the Council to manage a provider effectively when it was delivering a complex and sensitive service such as ASC.

Transferring the in-scope services to The Barnet Group, the Council's Local Authority Trading Company (LATC). The Barnet Group is wholly owned by the Council, which means any profits it generates can be returned to the Council. Stakeholders felt that some of the benefits of delegating services to The Barnet Group were the same as those that applied to delegating services to any external partner (such as "freedom" from Council policies and procedures). However some stakeholders also felt that some of the drawbacks associated with an external partner could also apply to this option, such as the risk that a partner would fail to deliver the level of service described in the procurement process.

Establishing a public service mutual organisation. In the strategic outline case this option was described as a social enterprise. This term has no legal definition in the UK and is used to describe a wide range of different organisational structures. Therefore in this paper the term "public service mutual" (PSM) is used as it summarises the key features of this option – it is independent from the Council, any profits it generates are re-invested in the service and it is at least partially owned by its staff. This concept of shared ownership and meaningful representation of staff and local people at management board level was very attractive both to staff and to service users. However, amongst both staff and service users, some were concerned that a small organisation could be financially vulnerable, especially in an environment where social care budgets are reducing every year.

The following options appraisal criteria were applied to the options:

Is there appetite amongst potential partners to deliver this option? Through informal market engagement, potential interest in delivering the ADM was identified amongst local NHS organisations and amongst organisations in the private and not-for-profit sectors. The opportunity was also explored with The Barnet Group. Staff in the Adults and Communities Delivery Unit expressed interest both in exploring the PSM option and in moving forward with a reformed in-house service.

Can statutory ASC functions be delegated under this option? The Care Act 2014 gives Councils the ability to delegate most statutory ASC functions in relation to assessment and care management, although they cannot delegate their statutory

duties, and some statutory functions would remain the responsibility of the Council under any ADM. Notwithstanding these limitations, at present there do not appear to be any legal barriers to any of the options carrying out delegated statutory ASC functions.

Could this option deliver the required cultural and process change? In order to deliver the new operating model, the ADM needs to create an environment in which:

- People's expectations of what the Council will do for them are "reset" and they are encouraged to take responsibility for living as independently as possible.
- Amongst staff, trust, professional autonomy and positive risk taking are promoted and decision-making is swift and unhindered by bureaucracy.
- The service works closely with partners including health, housing and organisations from the community and voluntary sector (CVS).

There is good evidence from examples such as Focus in North East Lincolnshire and People2People in Shropshire, that a PSM can be a highly effective way to create this kind of environment. The opportunity for staff to own a financial "stake" in the organisation, and the representation of staff on the PSM management board drives high levels of staff engagement. Local people can also be members of the PSM management board and directly influence its priorities and strategic direction.

A shared service with the NHS would present a significant opportunity to transform the way ASC services work with health services, both at a strategic level and in the way staff on-the-ground work together. If health and ASC services shared a pooled budget there would be more joined-up thinking around how people can be supported to lead more independent lives for longer.

It would be possible to deliver elements of the required level of change through a reformed in-house service but it would be a very slow and complex process. The service has a strong local identity and reputation as "the Council" and this could make it harder to persuade people and partners to change expectations and work with the Council in a different way.

Although The Barnet Group is a separate organisation, it also holds a strong identity as part of the Council. This could make it more difficult for The Barnet Group to reset expectations and develop new ways of working. The Barnet Group's status as a LATC (wholly owned by the Council) means there would not be an opportunity for staff and/or members of the community to share ownership of the ADM under this option.

Involving a partner from outside of the public sector in the ADM could help to accelerate implementation of the new way of working. However, there is no evidence of this model being used in other Councils to drive extensive culture and process change in ASC. There is also a risk that staff would feel disengaged from the service

and that partner organisations could be mistrustful and reluctant to work closely with the service if it were delivered by a private sector partner.

Could this option generate savings and/or additional income? The ASC ADM project has a savings target of £1.96m between 2017/18 – 2019/20.

Under a reformed in-house service, savings would be generated through a reduction in employee-related costs and some reduction in management overheads. The staffing savings would be realised through actions to review the skills mix of staff, increase staff productivity, review support services and improve the overall efficiency of the service.

Given the importance of its role in delivering the new operating model, under a reformed in-house service the Social Care Direct service would be reviewed and integrated with the teams that deliver professional social work. The senior management team of the Delivery Unit estimates this integration could realise efficiency savings. Further savings could also be achieved by providing ASC transport and school transport through a single service. This initiative is still under development so a conservative estimate has been made that a saving could be achieved over the savings period. These two savings opportunities have been applied to all of the ADM options.

Most of the savings under a NHS shared service would be generated through economies of scale and procurement savings on supplies and equipment. Under a pooled health and social care budget there would also be increased investment in ASC as a more cost-effective alternative to NHS in-patient services. Additional net income from a pooled budget, combined with income through trading services with the private sector and/or individual citizens is assumed under this option. Employee-related cost savings are assumed to be lower than those under a reformed in-house service because increasing the efficiency of the service will be more difficult as the service will be much larger and more complex than the current in-house service. However, the assumed saving on management overheads is assumed to be higher under a shared service because two services brought together would only need one senior management team.

Initial market testing intelligence indicates that in this context a private sector partner could realise efficiency savings equivalent to 10% of the in-scope services. Based upon the projected budget for employee-related costs and transport costs in 2017/18 (£14.6m) this gives an assumed total saving of £1.46m over the savings period.

The financial assumptions for the LATC option are very similar to those made for the reformed in-house service. The differences in the assumptions are 1) The Barnet Group is able to trade; and 2) savings through reducing employee-related costs are assumed to be lower because delivery of statutory ASC functions is a new service area for The Barnet Group.

ADM financial model

Assumed value of in-scope services, 2017/18	14,603,108

Saving opportunity	Risk	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Review Social Care Direct provision and delivery with close integration with professional social work teams	Low	Initial analysis shows this option is likely to achieve 86% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 85% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 74% of the £1.96m savings target as providers are likely to guarantee savings equivalent to 10% of the value of in-scope services.	Initial analysis shows this option is likely to achieve 82% of the £1.96m savings target.	Initial analysis shows this option is likely to slightly exceed the £1.96m savings target.
Reduce employee-related costs through productivity improvements, efficiencies, reviewing skills mix	Low					
Management overhead savings	Low					
Review support functions within Delivery Unit	Medium					
Efficiencies in contracts with health	Medium					
Passenger transport saving	Medium					
Enablement service	High					
Additional income from trading and other sources	High					
Total savings		**1,677,660**	**1,662,833**	**1,460,000**	**1,611,186**	**2,105,898**
Revised budget		**12,925,448**	**12,940,275**	**13,143,108**	**12,991,922**	**12,497,210**
Level of confidence in delivering and facilitating wider MTFS savings target (£13.1m)		85%	85%	85%	85%	95%
Therefore level of MTFS savings delivered from 2017/18 onwards		**11,141,035**	**11,141,035**	**11,141,035**	**11,141,035**	**12,451,745**
Total benefit to the Council		**12,818,695**	**12,803,868**	**12,601,035**	**12,752,221**	**14,557,643**
Rank		2	3	5	4	1

As an organisation independent from the Council, a PSM could have a much more streamlined organisation structure with faster decision-making and reduced bureaucracy. Therefore it is assumed a PSM could deliver employee-related cost savings and savings on management overheads through implementation of a flat management structure. Trading income is assumed, because staff would have a high level of incentive to generate income through trading. As the PSM would have a high level of control over how it spends any trading surplus, staff would be able to see a direct link between the PSM's trading activities and the money it has available to invest in service improvement.

Under a PSM the Delivery Unit proposes to reform the enablement service, with a greater emphasis upon occupational therapy, and staff development to increase skills around behaviour changes and use of equipment and preventative services. These reforms could realise efficiency savings over the savings period.

The ADM project also needs to support the achievement of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20, excluding the ADM project's own savings target of £1.96m). The level of confidence in meeting this target has been set at 95% if the service is delivered through a PSM, reflecting the high level of alignment between the operating model's aims and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are less well aligned with the operating model.

Has this option been tested by other Councils? The in-house model is in use by the majority of Councils and is well tested for the delivery of statutory ASC functions. There are also examples of PSMs and NHS shared services successfully delivering the full range of statutory ASC functions. However, there are no examples of a LATC or a provider outside of the public sector delivering the full range of statutory ASC functions on behalf of a Council. Given the essential nature of the ASC service, and the vulnerable people it supports, the Council needs to consider whether the potential benefits of the untested options justify the risks associated with pioneering a new approach.

Options appraisal summary

	Is there market appetite for this option?	Could this option carry out statutory social care functions?	Could this option deliver cultural and process change?	Could this option generate savings and/or additional income?	Has this option been tested by other Councils?
Public service mutual organisation	✓	✓	HIGH	HIGH	✓
NHS shared service	✓	✓	HIGH	MEDIUM	✓
Reformed in-house service	✓	✓	MEDIUM	MEDIUM	✓
LATC (The Barnet Group)	✓	✓	LOW	MEDIUM	✗
JV with partner outside the public sector	✓	✓	LOW	LOW	✗

It is proposed that the following options will not be taken further:

- A JV with a partner outside the public sector, as this is the worst performing option when judged against both the ability to generate savings and the extent to which it can support the required cultural and process change.
- Delegating the services to The Barnet Group, as although it has a track record as a social care provider organisation, its experience lies in providing social care services rather than delivering statutory ASC functions.

It is proposed that the following options will be taken forward to a detailed appraisal:

- A PSM appears to be the most effective way to deliver the required cultural and process change, and also has the strongest financial business case.
- A shared service with the NHS presents potential benefits arising from the integration of health and social care that could be highly significant.
- A reformed in-house service could deliver the required change, albeit more slowly than could be delivered through other ADMs.

The next stage of this project will be delivered through three workstreams:

1. Producing a further business case that develops each of the three shortlisted options in greater detail.
2. Continuing the work already initiated to prepare for the proposed new operating model through culture and process change.
3. Public consultation on how the new operating model should be implemented and on the proposed shortlist of ADM options.

Based upon the findings from these three workstreams, a preferred ADM will be recommended to the Adults and Safeguarding Committee in September 2016. The timescale for ADM implementation will depend upon which option is selected. Transformation of a reformed in-house service would take approximately 18 months to complete. A PSM could be established rapidly, within three months or more slowly, within 15-18 months, depending upon the implementation approach. A NHS shared service could be established within 12 months under a Section 75 Agreement. Implementation of a NHS shared service as an Accountable Care Organisation would take longer as this is a new form of NHS organisation.

2. Strategic context

The scale of the adult social care challenge

Adult social care (ASC) services face unprecedented pressures from:

- **The need to find significant financial savings.** The economic challenges the UK has faced over the past few years have meant Councils have needed to take some tough decisions in order to live within their means. In June 2014 the Council's Priorities and Spending Review (PSR) identified options to make savings and increase income by approximately £50.8 million between 2016/17 and 2019/20. £12.6m of savings were allocated to the Adults and Safeguarding Committee. A further £5.9m was added to the savings target in July 2015, bringing the total to £18.5m.

- **Growth in demand for ASC services.** Across the country rising life expectancies and medical advances are contributing to increased demand for ASC services. In Barnet the number of people aged 90 or above is projected to increase by 54.5% (an additional 1,900 people) between 2015 and 2025. There are also increasing needs among younger adults. In Barnet, the number of 18-24 year olds supported by ASC has increased by 25% in the last four years.

- **Requirements of the Care Act 2014.** The Care Act 2014 is the biggest reform of care and support in more than 60 years. Last year the Council estimated the cost of implementing the full Care Act 2014 in Barnet could be an additional £7.8m per annum[1].

- **Rising expectations of service users.** Advances in customer services and technology mean people have higher expectations of public services. This means many ASC service users, carers and their families will not be content with the Council's current service offer in the future. However, these advances also present opportunities for the Council to use new technologies to meet people's needs more effectively.

How the ASC challenge is being addressed in Barnet

In order to address these challenges the Council has made a number of changes[2] focused upon improving the efficiency, effectiveness and value for money of ASC services. These changes helped to deliver savings of £29.4m between 2010/11 and 2014/15.

[1] Adults and Safeguarding Commissioning Plan, 2015 – 2020, Appendix A (19 March 2015). http://barnet.moderngov.co.uk/documents/s22061/Adults%20and%20Safeguarding%20Commissioning%20Plan.pdf

[2] Summarised in the strategic outline case for a future operating model for adult social care, presented to the Adults and Safeguarding Committee on 12 November 2015: http://barnet.moderngov.co.uk/documents/s27172/Appendix%20A%20Strategic%20outline%20case%20for%20a%20future%20operating%20model%20for%20adult%20social%20care.pdf

However, the Council is approaching the limit of savings that can be achieved through providing services more efficiently. In particular, there is very limited scope to further reduce the cost of care services provided by external suppliers, which account for more than 80% of the Council's ASC expenditure.

There is therefore a need to find ways to reduce demand for Council-funded ASC services by helping people to stay healthy and well, supporting them to regain their independence after illness or injury, and encouraging them to make greater use of community resources as an alternative to Council-funded care and support.

A new operating model for ASC

In order to reduce demand for Council-funded ASC services at the necessary scale and pace, the way ASC is delivered in Barnet needs to be radically re-designed. Therefore in January 2015 the Adults and Safeguarding Committee approved a project to develop a new ASC model[3] for Barnet, based on the principles of:

1. Enabling people to regain and maintain their wellbeing so they don't need to call upon ASC services. Where people do need ASC support, the Council helps them remain in their own community and home for as long as possible.
2. For all people who use ASC, intervening at a much earlier stage and in a different way.
3. Maintaining or improving the Council's ability to meet its statutory ASC duties and keep the most vulnerable adults and older people safe.

It was agreed that to meet these principles, any new model needs to:

- Change the pattern of demand through a focus on very early intervention and prevention. This requires a significant shift from the current model that focuses resources on assessment once someone has social care needs.
- Introduce new processes that reduce duplication of effort and increase use of technology, mobile working and self-service. In practice this means making it easier for residents to assess their own requirements, obtain information and advice, decide what to do and then put their own plans into action.
- Draw upon services, information and advice offered by community groups, volunteers, the voluntary sector and local health services.
- Deliver assessment and support planning that focuses on people's strengths and what they can do for themselves, and draws upon support from their families and local communities.
- Produce innovative care plans that include non-traditional support such as technology to help with daily living.

[3] The Implications of the Commissioning Plan and The Care Act 2014 for Adult Social Care in Barnet (26 January 2015). https://barnet.moderngov.co.uk/documents/s20572/AS%20committee%20ADM%20report%20011v10.pdf

In November 2015 an approach to a new operating model for ASC was approved by the Adults and Safeguarding Committee[4]. The operating model is based on shared responsibility between the state, the community and the person. It encourages people to recognise their strengths and identify the support that their family, friends and the local community can give them.

The model proposes fundamental changes to what ASC practitioners do and, more importantly, to how they do it, in order to deliver a greatly improved ASC service for people in Barnet:

Cultural change

- A culture based on trust, professional autonomy and positive risk taking.
- Practitioners take a different approach to their work and apply new ways of thinking, new skills and new behaviours.
- Strong staff teams support and motivate practitioners as the new culture develops.
- Strong working partnerships are developed with CVS organisations, based on trust and transparency.
- Residents and service users are willing to re-think their expectations and interact with the Council in a different way.

+

Process change

- Emphasis on preventative services to keep people as healthy and well as possible.
- Emerging digital technology and innovation used to improve services and give residents 24/7 access to a range of information and services.
- People whose issues cannot be resolved over the telephone and who do not need a home visit will be invited to a hub appointment.
- An asset-based and community-led approach to supporting people.
- Statutory activities are joined up with the rest of the service.

=

Customer experience

People in Barnet will experience a service that is:

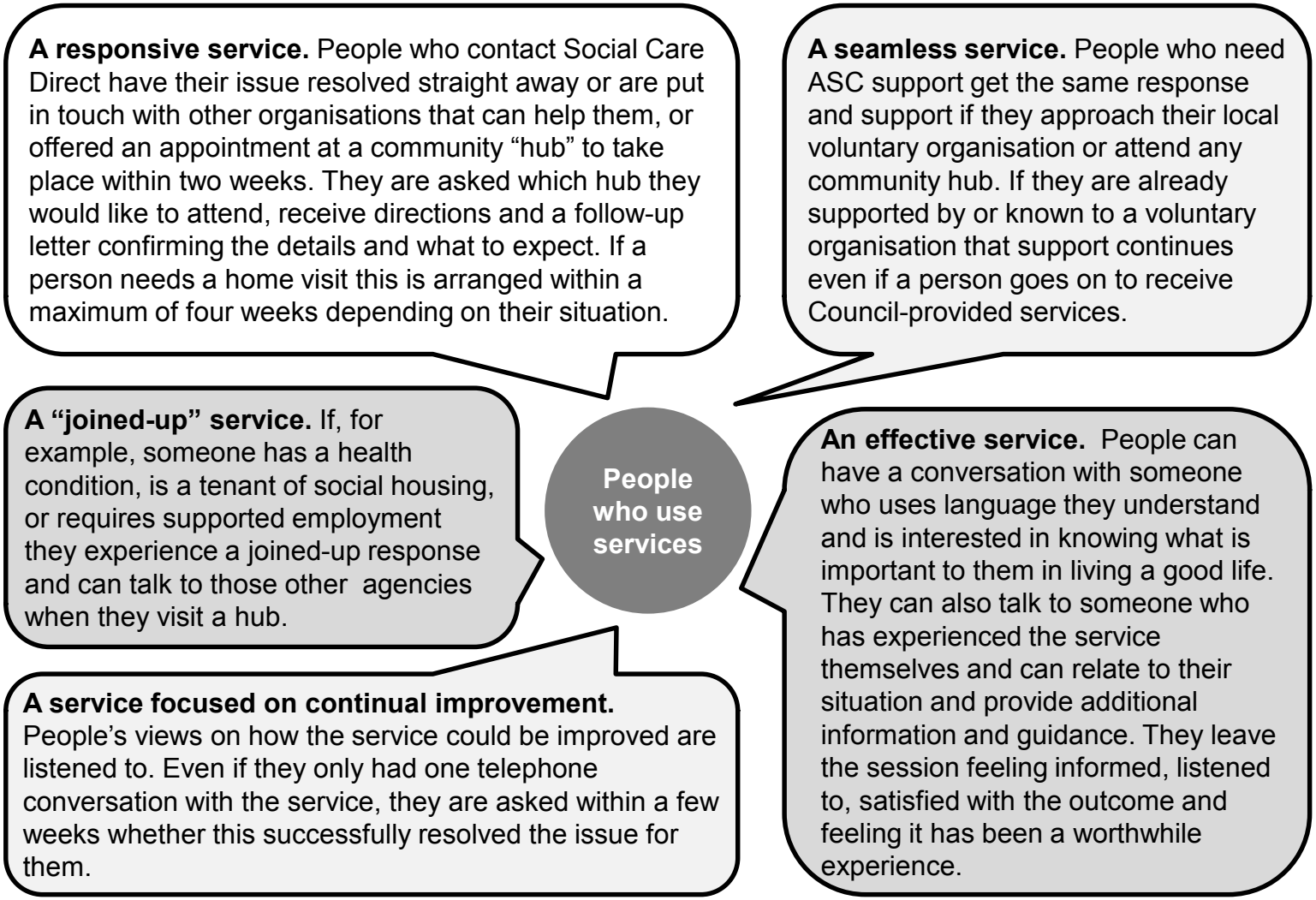
- Responsive.
- Seamless.
- Joined up with other agencies.
- Effective.
- Focused on continual improvement.

Individual practitioners would be asked to take a different approach to their work and apply new ways of thinking, new skills and new behaviours. They would be given greater autonomy and freedom to apply their professional judgment and develop new, better ways of working. The Council would also work differently with community and voluntary organisations, involving them as partners in the design, implementation and delivery of the new model.

A key feature of the operating model is a new way of responding to people whose issue cannot be resolved by Social Care Direct and who require more than a telephone conversation but do not necessarily need a home visit. These people would be invited to attend an appointment at a community hub, staffed by ASC workers and supported by voluntary organisations and other agencies.

[4] A New Operating Model for Adult Social Care: http://barnet.moderngov.co.uk/ieIssueDetails.aspx?IId=24852&PlanId=0&Opt=3#AI12597

The proposed new operating model will deliver a more personalised and person-centred customer experience:

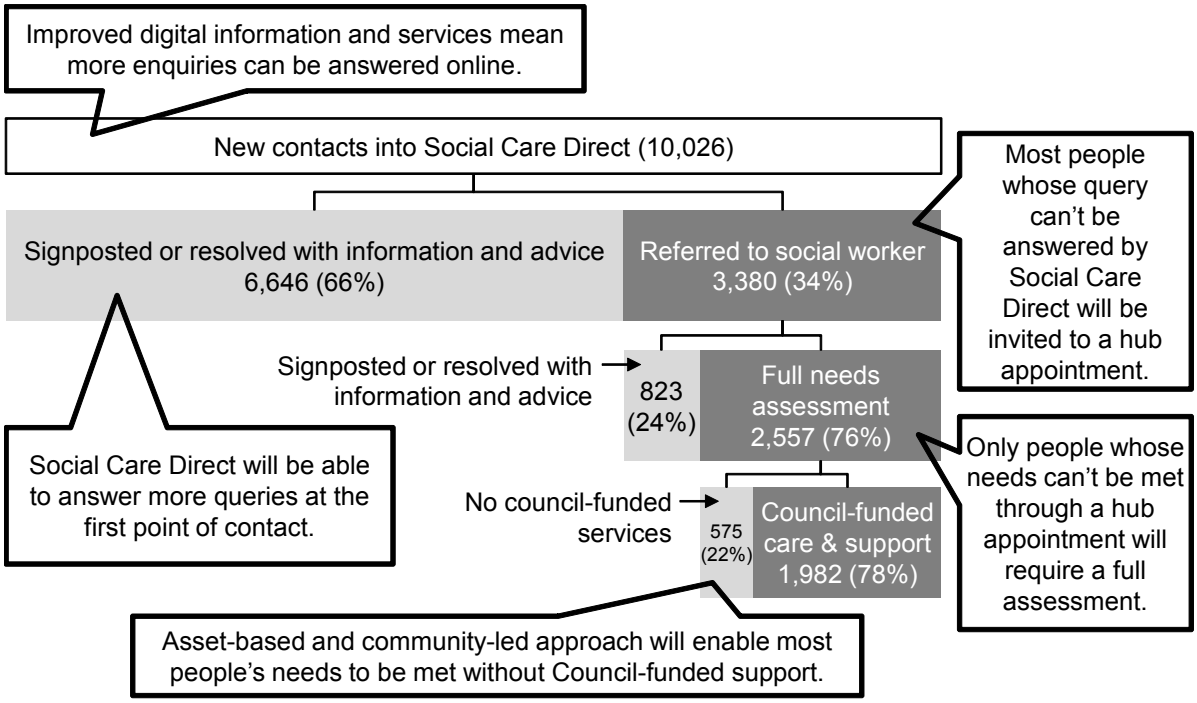


The proposed new operating model will enable changes in the way ASC is delivered across a number of elements of the service:

Area	Current status	What needs to change
Referrals	Approximately 38% of referrals to ASC come from secondary healthcare services.	Proactive social work in hospitals to promote higher take-up of enablement.
Assessments	Most people (76%) referred to a social worker by Social Care Direct receive a full needs assessment.	More people supported through asset-based “different conversations” without a full needs assessment.
Carers	Carer support services in place, but mostly following a reactive model.	More proactive carer support, with prevention plans in place for the most high risk cases.
Employment	5.2% of adults using MH services and 9.5% of adults using LD services are in paid employment.	Aim to have the highest employment rates for adults with learning disabilities / mental health needs in London.
Housing and support	Plans in place to develop more housing to support people’s independence.	Ensure an appropriate supply of housing to maximise independence.
Technology and adaptations	Telecare services focus on older adults with non-complex needs. Means-tested Disabled Facilities Grants (DFGs) are made available.	Significantly increase (at least double) the take-up of both telecare services and DFG grants across a range of different service user groups.
Community-led services	Some preventative services are commissioned from the CVS sector.	Greatly increased role in service development and delivery for local CVS organisations.
Hubs	Pilot of community hubs for assessments and reviews underway in three locations.	All assessments and reviews take place in a hub, unless a person cannot travel to a hub.
Productivity	Scope for improvement in practitioner productivity rates has been identified	Aim to have the highest practitioner productivity rates in London.
Reviews	Reviews are not always timely, and tend to recommend increased levels of support.	Reviews are asset-based, timely and always seek to maximise independence.

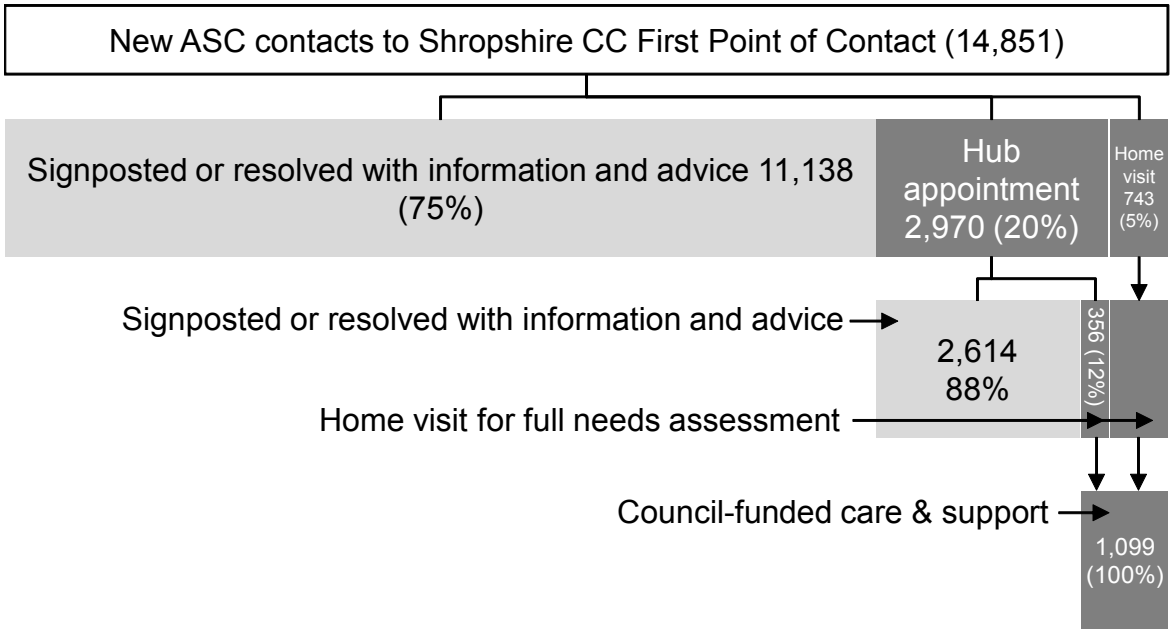
The evidence emerging from other Councils that have implemented similar approaches suggests this operating model would also support savings by reducing the number of new Council-funded care packages that are needed each year.

The following diagram, taken from the strategic outline case, shows the "flow" of people contacting Social Care Direct with ASC enquiries in 2014/15, and indicates the main ways in which the new operating model would change this flow:



Source: Referrals, Assessments and Packages of Care (RAP) return submitted by Barnet Council to the Health and Social Care Information Centre (HSCIC).

In Shropshire, a new operating model, focusing on cultural change to give staff greater professional autonomy and empower people to take responsibility for improving their lives, has enabled the following flow of ASC enquiries:



Source: People2People, Shropshire. Data reflects new ASC contacts in September 2015, excluding hospital referrals. Mental health enquiries that the First Point of Contact team cannot resolve with information and advice are signposted to Shropshire County Council's mental health team.

In Shropshire, 20% of people contacting the Council with an ASC enquiry are invited to attend an appointment at a community hub, and 88% of these people have their problems resolved through information and advice and/or signposting to local CVS groups, at no cost and without needing a full statutory ASC needs assessment. Only 5% of people contacting the Council with an ASC enquiry need face-to-face advice and are not able to attend a hub appointment (for example, because of a physical disability or caring responsibilities). These people receive a home visit from an ASC practitioner.

A new alternative delivery model for ASC

In January 2015 the Adults and Safeguarding Committee also agreed that the project should consider the full range of alternative delivery models (ADMs) through which the new operating model could be delivered:

- Reforming and delivering the service in-house. This could include bringing in specialists from other organisations (including the private sector) to support development of a new internal culture and ways of working.
- Extending the services provided through the Council's Local Authority Trading Company (LATC), The Barnet Group.
- Sharing services with public sector partner(s) such as other London Boroughs or local NHS organisations.
- Establishing a social enterprise or employee-led mutual organisation.
- Outsourcing or creating a joint venture with a third party supplier.

This list of options was based upon findings from previous Council projects exploring ADMs, combined with sector-wide best practice knowledge.

3. Project definition

Project objectives

The objectives of this project are to:

1. Develop a new ASC operating model, building upon the principles and characteristics agreed by the Committee in January 2015.
2. Identify the best ADM to deliver the new operating model, applying lessons learned from the Council's previous work on ADMs.

This project needs to realise savings of £1.96m[5] set out in the Council's medium term financial strategy (MTFS). It also needs to support the achievement of the remainder of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20) by reducing need for Council-funded services.

The output of the first stage of work, a proposed new ASC operating model, was presented to the Adults and Safeguarding Committee[6] in November 2015.

This document draws out the proposed new operating model and the changes required to implement it (in section 2, above) and presents the findings from the second phase of work, identifying the best ADM to deliver the proposed new operating model.

Project scope: services to be included in the ADM

The following principles have been applied to define which services should be included within the scope of the ADM.

1. The core activities carried out by ASC practitioners are:
    - Identifying people who need social care support.
    - Working with those individuals and their families to agree what support each individual needs in order to live a good life.
    - Arranging that support, or helping the person to arrange support for themselves.
    - Monitoring the support to ensure that it is effective and enables the person to achieve their goals.

All these activities (across all service user groups) should be within the ADM scope.

2. Other activities that are closely linked to and support the delivery of these core activities should also sit within the ADM. For example:

[5] £654,000 per annum in 2017/18, 2018/19 and 2019/20.

[6] A New Operating Model for Adult Social Care: http://barnet.moderngov.co.uk/ieIssueDetails.aspx?IId=24852&PlanId=0&Opt=3#AI12597

- Providing ongoing professional social work support for people with very complex needs.
- Arranging and providing short term enablement support as part of the process of identifying what long term support, if any, a person needs.
- Establishing a person's eligibility to receive Council-funded social care services (financial assessments) and associated financial services.

3. The range of ASC services that practitioners help people to identify and access are outside of the ADM scope.
4. Back office services (including IT, Finance, HR, Procurement and Estates) could be within or outside the ADM scope. This decision should be based upon specific practical and financial considerations.

Based upon these principles, the following services fall within the ADM scope.

- Services through which people who need social care support are identified:
    - First point of contact telephone and email services and online information and advice[7].
    - Urgent response team.
    - Hospital teams.
- Assessments and reviews, including needs assessments, conversations that don't constitute a full needs assessment, running the community hubs, financial assessments and home adaptation assessments.
- Occupational therapy and access to enablement services.
- Support planning and brokerage.
- Safeguarding activities, as these are aligned to identifying the need for ASC support and arranging ASC support. Also, all the channels through which safeguarding risks would be raised are within the ADM scope.
- Financial services: billing, deferred payments, Direct Payments monitoring, Care Accounts (from 2020).
- Gathering and maintaining good management information to inform decision making and ongoing improvement (business intelligence, performance, improvement). Best practice research suggests this function is most effective when it is a core part of the ADM.

Most of these services are delivered by the Council's Adults and Communities Delivery Unit but some are provided by external suppliers:

[7] Over time the Council's online platform will include more interactive services such as online self-assessment tools to enable people to assess their own social care needs and identify services and resources that they can access to meet those needs.

- Capita runs Social Care Direct (the “front door” to Barnet’s ASC services) as part of the Council’s wider customer services, and also manages the Delivery Unit’s online presence (including Social Care Connect, an online directory of ASC information, advice and services) as part of the Council’s wider information and communications technology (ICT) services.
- Enablement services are provided by Housing & Care 21, a not-for-profit care and housing provider.
- Barnet Centre for Independent Living’s Peer Support Planning and Brokerage Service helps people in Barnet to create their own support plans and arrange their support.

The customer services and ICT services provided to the Delivery Unit by Capita are provided under the Council’s corporate contract with Capita and it is assumed Capita would continue to provide these services under any ADM.

With the exception of these services, the ADM would hold the budget for all of the in-scope services, and be responsible for their delivery. It could sub-contract any of the services (partially or wholly) to other organisations. Processes would be needed to ensure the ADM had appropriate oversight of any sub-contracted services.

The following services would fall outside of the ADM and continue to be provided under the current delivery mechanisms.

Service	Interface with the ADM	Connections required with the ADM
Residential care, nursing care, home care, day care, respite care, telecare, Supported Living and home adaptations.	Practitioners help people to identify and access these services.	• Practitioners need detailed knowledge of these services. • The ADM needs to contribute to the Council’s market shaping decisions, to ensure the right blend of services is available in the medium and long term.
Care market management – planning and monitoring the Council’s requirements for care services. This is a strategic function that should remain within the Council.		
Services and support provided by CVS organisations.		

Service	Interface with the ADM	Connections required with the ADM
Preventative services and interventions (e.g. addressing social isolation; providing support for carers; helping people to stay fit and healthy). Commissioned by the Council's Commissioning Group and delivered by a range of providers, including CVS organisations.	The ADM needs to be aligned with the Council's overall prevention approach to prevention.	• The Council may commission the ADM to deliver specific preventative services and interventions.
Back office services: Finance, ICT, Procurement, Insight, Customer Services, HR (including payroll and pensions administration), Estates and Health and Safety.	The ADM is the client for these services, which need to support the efficient and effective operation of the ADM.	• The ADM should be able to define its own service requirements within the constraints of the Council's corporate contract.

Statutory functions

The Care Act 2014 does not allow Councils to delegate the following ASC functions[8] to other parties:

- Promoting integration of ASC provision with health provision and health-related provision (including housing).
- Deciding what services will be charged for, and setting the level of charges.
- Co-operating with relevant partners and other appropriate people, both generally and in specific individuals' cases.
- Adult safeguarding.

Therefore responsibility for these functions would need to remain with the Council. However the Council may commission or arrange for other parties to carry out related activities to support it in discharging the above functions. For example:

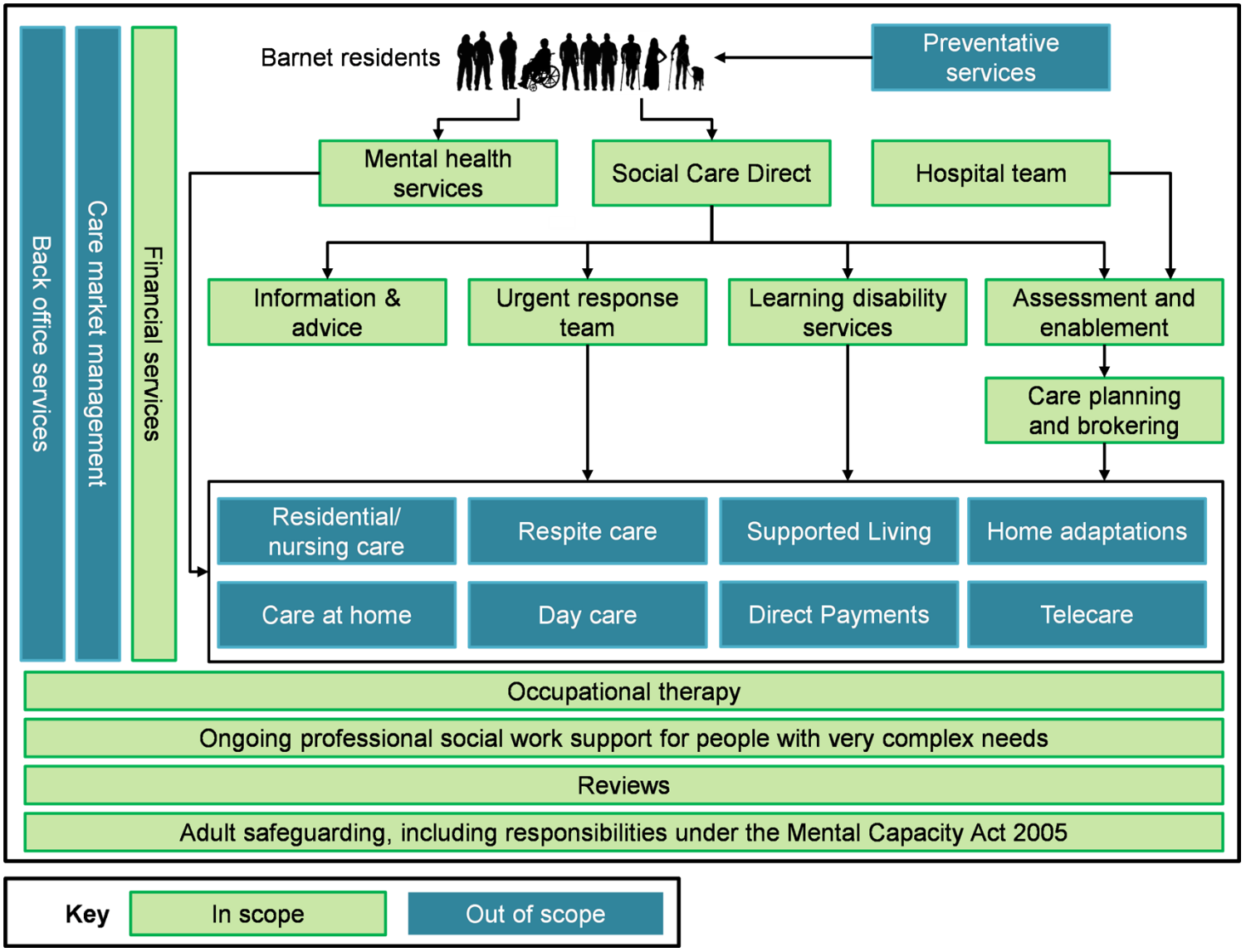
- The Council has overall responsibility for safeguarding but can ask the ADM to receive safeguarding alerts, carry out safeguarding enquiries and take appropriate follow-up actions on the Council's behalf.
- The Council must decide its own charging policies but can ask the ADM to carry out the administration, billing and collection of fees on its behalf.

[8] Section 79 of the Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/section/79/enacted.

Best Interest Assessors and Approved Mental Health Practitioners do not need to be employees of the Council. However, if they are not employed by the Council they cannot take proceedings in their own name and the Council must indemnify their actions.

The Council is the supervisory body for Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 does not allow for any other body to take this role. Any application to the Court of Protection for a DoLS authorisation would need to be made by the Council. Although DoLS assessments could be carried out by staff who are not Council employees, the person signing-off DoLS applications would need to be employed by the Council.

Summary of ADM scope



4. Methodology

Using the proposed new operating model as a point of reference, the project board provisionally agreed the scope of services to be included within the ADM (described in section 3). A set of appraisal criteria against which to judge the ADM options were also developed (described in section 6).

A number of workstreams were established to inform the options appraisal:

- Workshops with staff from the Adults and Communities Delivery Unit; with service users and their carers; and with representatives from local CVS organisations. These sessions aimed to explore what each of the stakeholder groups thought would be the potential strengths and weaknesses of each option, both for the Council and for themselves. The workshops followed on from meetings held with staff, service users and carers and local CVS groups between August - November 2015, to inform and shape the proposed new operating model. Appendix A provides a full list of the stakeholder engagement meetings carried out as part of this project.

- Informal market engagement: conversations and meetings with a sample of 13 potential partners and suppliers (including the Council's own Delivery Unit and its LATC, The Barnet Group) to test the extent to which these organisations have the appetite and capability to work with the Council to develop and operate the ADM.

- The senior management team of the Adults and Communities Delivery Unit developed a proposition for a reformed in-house service. This included consideration of how the service would need to change, how it would deliver the proposed new operating model and savings target, and what support and resources would be required. Conversations were also held with Capita to establish what support could be provided under the Customer Support Group (CSG) contract to support a reformed in-house service.

- Research into ADMs currently being used to deliver ASC, to identify why each model was chosen and what factors contributed to their success.

- Investigation of the different organisational forms through which an ADM could be established. This work built upon the best practice research that was conducted to inform the development of the proposed new operating model.

- The cost saving and income generating methods available to each ADM option were identified and used to produce a high level assessment of each ADM's ability to achieve this project's savings target.

- Legal advice was taken to check whether there were any legal barriers to implementing any of the options, based upon the ADM scope as defined in section 3.

The evidence gathered through these workstreams was presented to the project board at meetings held in December 2015 and January 2016, where the project board agreed the scoring of each of the ADM options against the appraisal criteria.

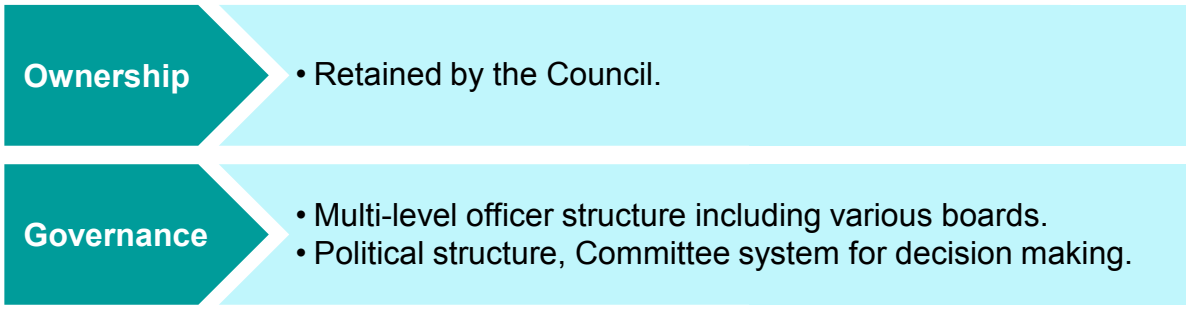
The project has also started to prepare for the proposed new operating model by working with the Adults and Communities Delivery Unit to initiate projects that develop the culture and process change required. A pilot to test use of community hubs to carry out assessments and reviews in a community location started in December 2015. A consistent asset-based approach to assessments and reviews is being developed, building upon the current practice of the Community Offer team (a social work and occupational therapy support service helping people live independently in their own homes). Best practice research shows the cultural and process changes required to put the new operating model into practice take time to deliver. Therefore this project aims to transform the service as much as possible whilst the service is still in its current form, to prepare for the implementation of the proposed new operating model and any future ADM.

5. Description of options and stakeholder feedback

This section describes the options under consideration, outlining the key features of each option and how they would be implemented. It also summarises stakeholder feedback on the options, gathered through workshops held with service users, carers and residents; representatives from local CVS organisations; and staff from the Adults and Communities Delivery Unit.

A reformed in-house service

The in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. Although no changes would be made to the overall governance of the services, this is not the "no change" option. A transformation programme would be undertaken to implement the new operating model and ensure the continued financial and operational sustainability of the service. This programme of transformation is described in Appendix B.



Potential benefits of a reformed in-house service

Some staff felt all of the changes described in the proposed new operating model could be delivered through an in-house service. They thought that as the in-house service is a tried-and-tested model and known to be an effective way to support people and keep them safe it was therefore the lowest risk option. Service users thought that retaining the in-house service would have the lowest "cost of change" and would enable continuity of the service.

Some staff felt that an in-house service can feel more "directly accountable" to the people it serves and others said they felt pride as Barnet Council employees.

Potential drawbacks of a reformed in-house service

Other staff thought that although it is possible to make the necessary changes through an in-house service, it would be a long process to make such significant changes, especially to change the working culture and "chisel away" at unnecessary bureaucracy. Some staff thought the necessary changes could not be made through an in-house service. Some service users and carers agreed: they thought that making change happen within the Council structure is hard, and that it would be difficult to "turn the service around" under the current model.

A shared service with one or more NHS partners

The Council would join up with one or more local NHS organisations to deliver integrated health and social care services. A single organisation would be responsible for the delivery of local health services and ASC services. There are a number of different governance structures through which a NHS shared service could be implemented. Examples of the different ways in which other Councils have implemented shared services with the NHS are provided in Appendix C.

Ownership	• Jointly owned by the Council and its NHS partner(s); or the Council could delegate ASC functions to the NHS partner.
Governance	• A number of governance structures could be considered, including creating an Accountable Care Organisation.

Alternatively, the Council could join up with one or more other Councils to deliver ASC services. This would deliver cost savings through economies of scale, but would not deliver any of the benefits that come from integrating health and social care. Given the growing momentum around health and social care integration[9], it would be a missed opportunity to develop a shared service with another Council that did not include at least one NHS partner. Therefore the options appraisal will consider a shared service with another local authority only as part of developing a shared service with one or more NHS partners.

Potential benefits of a NHS shared service

Staff, service users and local CVS representatives all saw the potential of a shared service to improve and accelerate health and social care integration and provide what they described as a more "holistic" service. One service user though that if health and social care services shared a single budget their objectives would be more likely to be aligned and they would be incentivised to work more effectively together. Some staff though that there could be economies of scale from joining up with a NHS partner, and identified some specialist services, such as the out-of-hours service, that could be delivered more efficiently at a larger scale.

Potential drawbacks of a NHS shared service

Staff, service users and local CVS representatives expressed concern that a NHS organisation would be the much larger partner and would therefore "dominate" the partnership, resulting in the social care agenda being subordinated to a health agenda.

[9] In particular, the announcement in the Government's Spending Review of November 2015 that each part of the country will be required to develop plans for the integration of health and social care services by 2017, to be implemented by 2020.

Some service users thought a shared service would be the most challenging option to implement, because it would require two (or more) organisations to be transformed instead of one. They felt the success of this option depended upon finding the right organisation to share services with. Some staff thought it would be difficult to find a local partner organisation that shared the Council's vision and was able to move at our pace. Other staff felt that integrating the working processes and ICT systems of two or more partner organisations would be complex and time-consuming.

A number of risks were also noted by staff and service users: what would happen if the other partner ran into financial difficulties? Could a shared service result in a loss of local accountability and a diminishing of Barnet's local individuality?

A partnership outside the public sector

This option could be implemented as an outsourcing arrangement, where an external provider delivers the services for the Council, or a joint venture (JV), where a JV company is created, jointly owned by the Council and an external provider. Given the complexity and risk inherent in the in-scope services, it is assumed that this option would be implemented as a JV, as this would give the Council a greater level of control over the day-to-day delivery of the services. Appendix D presents summary findings from conversations held with a sample of potential providers to test the appetite and capability of these organisations to work with the Council to develop and operate a JV partnership.

Ownership	• Jointly owned by the Council and an external provider.
Governance	• New company created with both the Council and external provider represented on the Board. Delivery Unit staff would transfer employment to the new company.

Potential benefits of a JV with a partner outside the public sector

Staff noted that the Council already manages external partners and therefore they thought it has the necessary experience and expertise in contract management. Some staff thought the private sector could bring additional funding to invest in service improvement, and that staff might have greater "freedom" from Council policies and procedures if they worked within a private sector organisation.

Potential drawbacks of a JV with a partner outside the public sector

Some staff were concerned that a private sector organisation would not have a strong public service ethos and would be less focused upon meeting the needs of individual service users and carers. Some service users also felt that an organisation outside of the public sector may not understand the specific issues affecting people

who use social care services. A question was raised by service users about whether it would be more difficult to manage a provider effectively when it was delivering a complex and sensitive service such as ASC, that potentially carries a high level of risk. Across all the different stakeholder groups (staff, service users and CVS representatives) there were some who felt that it was not appropriate for any organisation to generate a profit from providing ASC services.

Some staff also felt there were risks around suppliers failing to deliver the level of service described in the procurement process, and in the longer term, that the supplier may not share the Council's long term strategic vision.

Service users felt it would be important for any provider that was not based in Barnet to understand the local context, and to maintain a visible presence in Barnet.

Local Authority Trading Company (The Barnet Group)

Under this option, the in-scope services would transfer to The Barnet Group, which is the Council's LATC. The Barnet Group is wholly owned by the Council and this means any profits generated by The Barnet Group can be returned to the Council. The Barnet Group put forward a proposal for how it would deliver the in-scope services, which is summarised in Appendix E.

Ownership	• The Barnet Group is wholly owned by the Council.
Governance	• A subsidiary company would be created to hold the in-scope services of the ADM. Delivery Unit staff would transfer employment to the subsidiary company.

Reaction to LATC (The Barnet Group)

In comparison to the other ADM options, the option of moving services to The Barnet Group stimulated less reaction and discussion from stakeholders. Staff felt that some of the benefits of delegating services to The Barnet Group were the same as those that applied to delegating services to any external partner. For example, greater "freedom" from Council policies and procedures. However, some service users and staff also felt that a number of the potential drawbacks associated with delegating services to an external partner outside of the public sector could also apply to this option, such as the risk that a partner would fail to deliver the level of service described in the procurement process.

A public service mutual organisation

In the strategic outline case presented to the Adults and Safeguarding Committee in November 2015 this option was described as a social enterprise. The term "social

enterprise" has no legal definition in the UK and is used to describe a wide range of different organisational structures. Therefore in this paper the term "public service mutual" (PSM) is used, as it summarises the key features of this option – that it is independent of the Council; that any profits it generates are re-invested in the service; and that it is at least partially owned by its staff.

Appendix F contains further information about the features of a PSM; findings from research into PSMs delivering statutory ASC services; and a summary of the service development opportunities that could be explored under a PSM.

Ownership	• Could be 100% owned by the PSM staff; jointly owned by PSM staff and the local community; or jointly owned by PSM staff and the Council.
Governance	• New not-for-profit company created. Board membership would reflect the PSM's ownership structure. • Senior management team of Delivery Unit would become the leadership team of the PSM.

Potential benefits of a PSM

A number of staff felt a PSM could be the most effective way to restore some of the good social work practice that had been gradually eroded since the Community Care Act (1992), when practitioners were more embedded in their local communities and had greater freedom to implement innovative practice and autonomy to explore local solutions. There was scepticism amongst some staff that it would be possible to make these kinds of changes within an in-house service.

The concept of shared ownership and meaningful representation of staff and local people at management board level was very attractive both to staff and to service users. Representatives of Barnet's community and voluntary sector also liked the idea of practitioners being supported to develop their own, staff-led organisation. As their own organisations were charities or social enterprises they understood the potential benefits that these structures could have for the service, in particular, enabling much greater flexibility and creativity.

Staff thought a PSM presented an opportunity to build an organisation with a real focus on supporting people and where the staff share a set of common values. Some felt it had the potential to be the most "exciting" option in terms of the scale and pace of change to working practices that it could enable.

Potential drawbacks of a PSM

Both staff and service users were concerned that a small organisation could be financially vulnerable, especially in an environment where social care budgets are reducing every year. Both also thought that the Council would need to be sure there

was sufficient staff appetite to implement a PSM, in order to ensure the success of the new organisation, and to manage the risk of staff deciding to leave the service.

It was noted that the best practice examples of PSMs had a smaller scope than the proposed ADM scope for Barnet. Some staff asked whether there could be additional risks associated with the broad range of services within the scope of this project.

Some of the stakeholder feedback applied to all of the ADM options with the exception of a reformed in-house service.

Potential benefits of moving the service outside of the Council

Some staff, service users and CVS representatives thought that, in the short term, the process of moving outside of the Council could provide a "kick-start" for transformation and make it easier to make changes more quickly. In the longer term, some staff felt that moving outside of the Council could increase the flexibility and agility of the service.

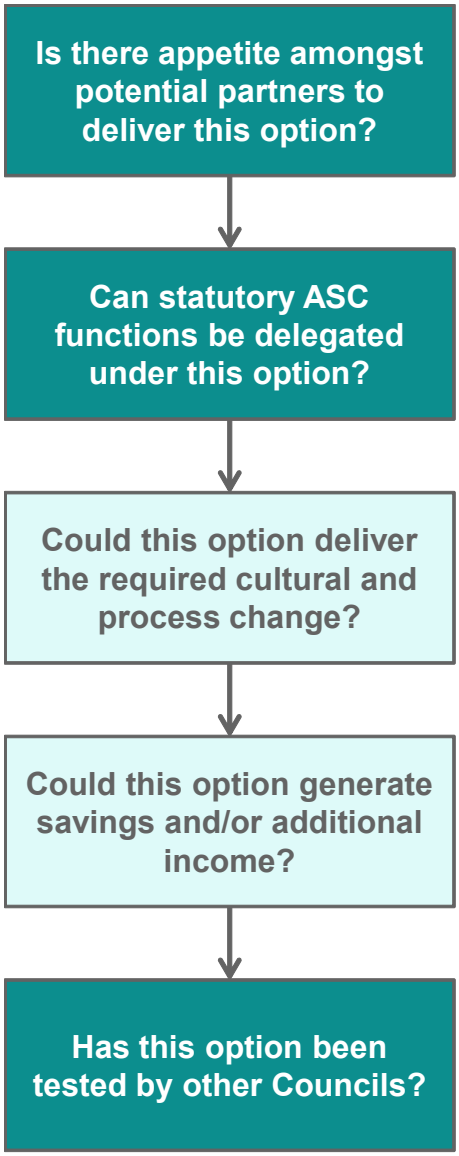
Potential drawbacks of moving the service outside of the Council

Some staff and service users questioned the extent to which a new model could reduce the bureaucracy of the in-house service, because the service would still have a responsibility to follow legal requirements. Some thought there could even be additional bureaucracy because the Council would need to monitor the performance of any externally-delivered service.

Other staff thought the process of implementing a new model could divert money and effort away from service improvement. In particular, they felt there was a risk that moving to a new model could have an adverse effect upon staff turnover and retention.

6. Options appraisal

The following options appraisal criteria have been agreed by the project board:



The first two criteria applied are gateway criteria, where the outcome is either pass or fail. An option that fails either of these criteria is not feasible and will not be taken forward in this process.

There are then two ranking criteria, where the outcome against each criterion is high, medium or low.

There is then a final gateway criterion. Any option that fails this criterion will not be taken forward unless it has achieved a "high" score in at least one of the two ranking criteria.

Is there appetite amongst potential partners to deliver this option?

Three of the ADM options depend upon the Council being able to find a partner or supplier organisation that is interested in providing the services.

- NHS shared service. In informal market engagement, conversations were held with two local NHS Trusts, which indicated interest in this option.
- A partnership outside the public sector. In informal market engagement, conversations were held with nine different organisations from the private and not-for-profit sectors. All of these organisations expressed potential interest in the opportunity, four as “prime contractors” leading a consortium bid, and five who expressed an interest in delivering some of the in-scope services as part of a consortium bid.
- Delegation of services to the Council’s LATC. This has been explored with the Barnet Group, which has a track record of taking on the provision of services from the Council.

This suggests sufficient potential interest to consider each of these options further.

The PSM model would be staff-led and therefore is only feasible if staff are enthusiastic about developing and working within such a model. The leadership team of the Adults and Communities Delivery Unit has indicated its strong interest in exploring the PSM delivery model. In workshops held with staff from the Adults and Community Delivery Unit in December 2015, interest and enthusiasm was expressed about the PSM option. Other staff said that their preference was to move forward with a reformed in-house service.

Can statutory ASC functions be delegated under this option?

The Care Act 2014 gives Councils the ability to delegate statutory ASC functions in relation to assessment and care management (although Councils cannot delegate their statutory duties). The Act places no restrictions upon the type of organisation to which a Council may delegate its statutory ASC functions.

As described on pp20-21, some statutory functions and activities would remain the responsibility of the Council under any ADM.

Notwithstanding these limitations, at present there do not appear to be any legal barriers to any of the options carrying out delegated statutory ASC functions. Therefore all of the ADM options “pass” this criteria at this stage in the process. Exploration of the shortlisted options in greater detail in the next phase of the project may identify legal issues that need to be considered.

Could this option deliver the required culture and process change?

The proposed new operating model is a new way of working that aims to:

- Continue to keep people safe.
- Achieve better outcomes for individuals, so that people enjoy greater independence, feel more in control of their lives, are able to stay in their own homes, have a job and live close to friends and family.
- Help people to increase their own personal resilience and, where needed, to draw upon support from their family, friends, social networks and services provided by community groups and the local voluntary sector.
- Meet needs at lower cost.
- Support delivery of the Adults and Safeguarding Committee's overall savings target (£13.1m between 2017/18 and 2019/20, excluding the ADM project's own savings target of £1.96m).
- Establish a service that is financially sustainable in the long term.

In order to deliver the new operating model, changes need to be made to what ASC practitioners do (their processes) and, more importantly, how they do it (their culture and working practices). This means any ADM needs to address:

- The way people use the service. People's expectations of what the Council will do for them need to be "reset" and individuals need to be encouraged to take responsibility for living as independently as possible.
- The way staff work. A dynamic culture based on individual practitioner motivation and values should encourage staff to innovate and take the lead on developing practice and partnerships. Trust, professional autonomy and positive risk taking should be promoted and decision-making should be swift and unhindered by bureaucracy.
- The way the service works with its partners. The service should work closely with partners including health, housing and CVS groups, to deliver a seamless, joined-up service. There needs to be a greater role and a higher profile for CVS organisations, and for individual volunteers.

PSM: There is good evidence, from examples such as Focus in North East Lincolnshire and People2People in Shropshire, that a PSM can be a highly effective way to deliver the change described above. The opportunity for all staff members to own a financial "stake" in the organisation, and the representation of staff on the PSM management board drives high levels of staff engagement. A streamlined management structure means decisions can be taken much more quickly, which makes it much easier to introduce innovative practice. As a new organisation with its own identity a PSM is well-placed to "disrupt" pre-existing ideas of what people can

expect from social care. Local CVS organisations are much more likely to think of a PSM as “one of us” and be keen to share resources and work collaboratively with it. Local people can also be members of the management board of the PSM and directly influence its priorities and strategic direction.

NHS shared service: A shared service would present a significant opportunity to transform the way ASC services work with health services, both at a strategic level and in the way staff on-the-ground work together. Delivering health and social care support through a single service would encourage practitioners to think about what each person needs in order to lead a good life, rather than focusing upon a person’s “health needs” and “social care needs”. However, it would be important to ensure that a strengthened partnership between ASC and health services did not crowd out partnership working with other services such as housing and employment support.

Integrating health and social care services would also help to align financial incentives. If health and ASC services shared a pooled budget through an Accountable Care Organisation (ACO) model, there would be more joined-up thinking around how people can be supported to lead more independent lives for longer. This could lead to increased investment in social care as a more cost-effective alternative to NHS in-patient services and is in line with the national policy direction for health and care.

Reformed in-house service: It would be possible to deliver elements of the required level of change through a reformed in-house service but it would be a very slow and complex process. The current in-house service has delivered a number of service improvements that have moved the service towards the proposed new operating model, but these have been pockets of change rather than “whole system” transformation. There are no examples of a Council successfully transforming the culture of its ASC service in line with the model set out in the strategic outline case through an in-house delivery model.

The service has a strong local identity and reputation as “the Council”. This means it already has strong partnerships with local partners and CVS organisations. However this identity could make it harder to persuade people and partners to change expectations and work with the service in a new way. As part of the Council, it is challenging to implement a community-led approach, where the strategic direction is set by staff, service users, carers, local CVS organisations and residents.

LATC: Although The Barnet Group is a separate organisation, there remains a strong perception amongst staff and service users that it is “part of the Council”. This could make it more difficult for The Barnet Group to reset expectations and develop new ways of working with staff, service users and partner organisations. An additional challenge is presented by The Barnet Group’s status as a LATC, which is 100% owned by the Council. This means there would not be an opportunity for staff and/or members of the community to share ownership of the ADM under this option.

This limits the extent to which staff and service users could be involved in setting the strategic direction and priorities of the new organisation.

JV with a partner outside the public sector: Involving a significant new partner in the service could help to accelerate implementation of the new way of working. The Council would also benefit from the partner's work beyond the Council. For example, if a partner has helped to implement innovative technology in another local authority, Barnet would benefit from the knowledge and experience the partner gained through delivering that work. However there is no evidence of this ADM being used in other Councils to drive extensive culture and process change in ASC. If the supplier is a private sector company[10] there is a risk staff could feel disengaged from the service and that partner organisations could be mistrustful and reluctant to work closely with the service. If the supplier did not have a strong track record in ASC it may lack credibility and struggle to develop strong relationships with partner organisations.

"Future proofing" the service

Any ADM must be able to adapt to any future changes made by central government to the way ASC is organised, funded or delivered. An in-house service has a clear advantage in this respect, because it is wholly under the control of the Council. Changes would be more difficult to implement under other ADMs, because the Council (which, as it cannot delegate its statutory duties, would retain responsibility for implementing any changes) would be asking a separate organisation to make any necessary changes.

This does not necessarily rule out any of the ADM options. The research carried out by the project has identified examples of PSMs and NHS shared services responding to national policy, such as implementing new requirements from the Care Act 2014. However, a partnership outside the public sector could reduce the Council's future options around delivering health and social care integration because a NHS organisation may be unwilling to delegate services to a private sector organisation. Nonetheless under any of the ADM options that involve a partner organisation, the Council will need to think carefully about how it builds in the necessary flexibility to amend contracts to reflect any future changes in central government policy.

[10] Based upon the findings from informal market engagement, it is highly likely that the prime contractor in any partnership outside the public sector would be a private sector company.

Could this option generate savings and/or additional income?

It should be recognised that, at this stage in the evaluation process, the financial and commercial assessment can only be an educated estimate, based on a series of assumptions about the services and the market. Modelling has been carried out at a level that is appropriate to enable a comparison of the different options' ability, relative to each other, to generate efficiency savings and additional income. It is not intended that the modelling should provide the greater level of certainty that one would expect with a detailed business plan.

The following table provides a high level summary of the outcomes of the financial modelling.

ADM financial model

Assumed value of in-scope services, 2017/18	14,603,108

Saving opportunity	Risk	Reformed in-house service	NHS shared service	Partnership outside the public sector	The Barnet Group	Public service mutual
Review Social Care Direct provision and delivery with close integration with professional social work teams	Low	Initial analysis shows this option is likely to achieve 86% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 85% of the £1.96m savings target.	Initial analysis shows this option is likely to achieve 74% of the £1.96m savings target as providers are likely to guarantee savings equivalent to 10% of the value of in-scope services.	Initial analysis shows this option is likely to achieve 82% of the £1.96m savings target.	Initial analysis shows this option is likely to slightly exceed the £1.96m savings target.
Reduce employee-related costs through productivity improvements, efficiencies, reviewing skills mix	Low					
Management overhead savings	Low					
Review support functions within Delivery Unit	Medium					
Efficiencies in contracts with health	Medium					
Passenger transport saving	Medium					
Enablement service	High					
Additional income from trading and other sources	High					
Total savings		**1,677,660**	**1,662,833**	**1,460,000**	**1,611,186**	**2,105,898**
Revised budget		**12,925,448**	**12,940,275**	**13,143,108**	**12,991,922**	**12,497,210**
Level of confidence in delivering and facilitating wider MTFS savings target (£13.1m)		85%	85%	85%	85%	95%
Therefore level of MTFS savings delivered from 2017/18 onwards		**11,141,035**	**11,141,035**	**11,141,035**	**11,141,035**	**12,451,745**
Total benefit to the Council		**12,818,695**	**12,803,868**	**12,601,035**	**12,752,221**	**14,557,643**
Rank		2	3	5	4	1

Delivering the ADM savings target

The ASC ADM project has a savings target of £1.96m between 2017/18 - 2019/20. All references to “the savings period” in this section refer to this three year period.

Reformed in-house service

Under this option, savings would be generated through a reduction in employee-related costs and some reduction in management overheads. The staffing savings would be realised through actions to review the skills mix of staff, increase staff productivity, review support services and improve the overall efficiency of the service.

The Council’s strategic partnership with Cambridge Education enables efficiencies to be realised by providing school transport. ASC transport is having initial conversations about providing the brokerage through a single service. This initiative is still under development so a conservative estimate has been made that a saving could be achieved over the savings period.

The proposed new operating model emphasises the crucial role that Social Care Direct (SCD) has to play in providing information and advice, and signposting people to relevant services outside of the Council. Given the importance of SCD in the new operating model, under a reformed in-house service the SCD team would be reviewed and integrated with the teams that deliver professional social work. The senior management team of the Delivery Unit estimates this integration could realise efficiency savings.

A shared service with one or more NHS partners

Most of the savings under this option would be generated through economies of scale and procurement savings on supplies and equipment.

It is assumed that one of the partners in a shared service would be a NHS Foundation Trust. This would allow the shared service to trade services with the private sector and/or with individual citizens[11]. The service could explore a range of different trading opportunities such as retailing and hiring out daily living aids and equipment; or offering telecare services for self-funders. The service could offer its expertise in areas such as health and social analytics and care home quality monitoring to other organisations. Therefore achievable net income is included in the savings period.

Further income is also assumed under this option as best practice research suggests under a pooled social care and health budget there would be increased investment in ASC from the NHS as a more cost-effective alternative to NHS in-patient services.

11 Councils may only trade with the private sector or with individual citizens through a separate company. NHS Foundation Trusts are autonomous bodies and are therefore able to trade in their own right.

Employee-related cost savings are assumed over the savings period. However these savings are lower than the savings assumed under the reformed in-house service because increasing the efficiency of the service will be more difficult under a shared service, as the service will be much larger and more operationally complex than the current in-house service. However, in the longer term it should be possible to realise more significant savings.

The assumed saving on management overheads is assumed to be higher under a shared service than under a reformed in-house service. The rationale is that two services brought together would only need one senior management team and this could deliver an increased reduction in management overheads.

A shared service would realise the same savings from ASC transport efficiencies and from integrating the SCD service as the reformed in-house service.

A partnership outside the public sector

Initial market testing intelligence has indicated that in this context a private sector partner could realise efficiency savings equivalent to 10% of the in-scope services. For the purposes of modelling, the total value of the in-scope services is assumed to be equal to the projected budget for employee-related costs and transport costs in 2017/18 (£14.6m). This gives an assumed total saving of £1.46m over the savings period.

Local Authority Trading Company (The Barnet Group)

In the following respects the assumptions for this option are the same as those for the reformed in-house service: reviewing support roles; management overhead savings; savings on transport; and efficiencies from closer integration of the SCD team with professional social workers.

As a LATC, The Barnet Group is able to trade and therefore this option would also benefit from the freedom to generate a profit from trading services with the private sector and/or with individual citizens. It is assumed that The Barnet Group would have higher levels of commercial expertise than a NHS shared service and therefore its assumed level of net trading income over the savings period is higher than the NHS shared service option.

Savings through reducing employee-related costs are assumed to be lower under this option than under a reformed in-house service. As delivery of statutory ASC functions would be a new service area for The Barnet Group, it would take some time to establish the service fully before beginning to implement changes to improve the productivity and efficiency of the service. Therefore it is assumed that The Barnet Group could deliver savings in relation to employee-related costs over the savings period but these would be lower than savings under a reformed in-house service.

Public service mutual organisation

As an organisation independent from the Council, a PSM could have a much more streamlined organisational structure, with faster decision-making processes and reduced bureaucracy. This would mean it could introduce changes to improve the efficiency of the service more quickly than would be possible under an in-house service. Therefore it is assumed that a PSM could deliver employee-related cost savings.

The assumed saving on management overheads applied to the in-house option has been increased under a PSM because research into comparable PSMs suggests a PSM could be implemented with a very flat management structure, and this would deliver a significant reduction in management overheads.

Like a LATC and a shared service, a PSM could generate trading income. Higher net income over the savings period has been assumed for a PSM because as an independent organisation it would have greater control over how it spends its trading surplus. The incentive for staff to generate income through trading would be higher because they could see a direct link between the PSM's trading activities and the money it has available to invest in service improvement. Best practice research also suggests the sense of ownership that staff have from holding a financial "stake" in a PSM encourages a much more entrepreneurial culture.

The Delivery Unit proposes to reform the enablement service, with a greater emphasis upon occupational therapy, and staff development to increase skills around behaviour change and use of equipment and preventative services. The Delivery Unit's senior management team estimates these reforms could realise efficiency savings over the savings period.

The PSM would also benefit from some procurement savings on supplies and equipment, though to a much lesser extent than a shared service.

It is also assumed that a PSM could realise the same savings from ASC transport efficiencies and integrating the SCD service as the reformed in-house service.

Supporting the wider savings target

The Adults and Safeguarding Committee has an overall savings target of £18.5m between 2016/17 and 2019/20. The Committee's savings proposals[12] assume total savings of £3.4m in 2016/17, and a saving of £1.96m to be delivered directly by the ADM project in the period 2017/18 to 2019/20 (as outlined in the section above). This leaves a saving of £13.1m between 2017/18 and 2019/20 that the ADM needs to enable and support by reducing need for Council-funded services.

[12] Approved by the Council's Policy and Resources Committee on 16 December 2015. http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=692&MId=8349&Ver=4

The level of confidence in meeting this £13.1m savings target has been set at 95% if the service is delivered through a PSM organisation. This confidence rating reflects the high level of alignment between the aims of the proposed new operating model and the key features of a PSM. The confidence rating for the other options has been set lower, at 85%, as these options are not so well aligned with the operating model.

Has this option been tested by other Councils?

Local authorities have only been able to delegate certain statutory ASC functions, such as assessment of need, since the implementation of the Care Act in April 2015. Therefore the market for providing these services outside Councils is still emerging. There are few examples of the full range of statutory adult social work being delivered through ADMs. It is important to recognise that implementing any ADM (other than a reformed in-house service) in these areas would mean following a path that, so far, has been taken by very few other Councils.

Although the Council has experience of delivering services through all of the ADM options, some have not been used before for such a large service area, or for services that carry such inherent risk and complexity.

ASC is an essential service that supports vulnerable people. Any failure of the service to look after people and keep them safe could have devastating consequences. The current service is not robust, with an overspend forecast in this financial year and significant savings targets in future years, which are reliant on the reduction of need for statutory care for their achievement. In this context it would not be responsible to select an ADM that has never been tested as a way to deliver statutory social care functions.

The in-house service delivery model is in use by the majority of local authorities and is well tested for the delivery of statutory ASC functions. The other ADM options have been tested to a lesser extent:

- There are two examples of PSMs successfully delivering the full range of statutory ASC functions: Focus in North East Lincolnshire and People2People in Shropshire.
- There are also examples of NHS shared services delivering the full range of statutory ASC functions, including Torbay Council, Staffordshire County Council, SEQOL (Swindon) and Sirona (Bath and North East Somerset).
- Although there are a number of LATCs which provide social care provider services such as home care and day services, there are no examples of a LATC delivering the full range of statutory ASC functions on behalf of a Council. The closest example identified is Optalis in Wokingham, which

carries out some initial assessments as part of a wider offer of care and support services.

- There are also no examples of a provider outside of the public sector delivering the full range of statutory ASC functions on behalf of a Council, although some providers have experience of providing some of the services within the ADM scope but across a number of different contracts.

Across those options that are untested or less tested, the Council needs to consider whether the potential benefits those options present are sufficient to justify the Council accepting the risks associated with pioneering a new approach.

Options appraisal summary

	Is there market appetite for this option?	Could this option carry out statutory social care functions?	Could this option deliver cultural and process change?	Could this option generate savings and/or additional income?	Has this option been tested by other Councils?
Public service mutual organisation	✓	✓	HIGH	HIGH	✓
NHS shared service	✓	✓	HIGH	MEDIUM	✓
Reformed in-house service	✓	✓	MEDIUM	MEDIUM	✓
LATC (The Barnet Group)	✓	✓	LOW	MEDIUM	✗
JV with partner outside the public sector	✓	✓	LOW	LOW	✗

Conclusion

The following options will not be investigated further:

- A JV with a partner outside the public sector. This is the worst performing option judged against both the ability to generate savings and the extent to which it can support the required process and cultural change. In this context there are not sufficient benefits to justify the potential risk of delegating such a wide range of statutory ASC functions to an untested provider market.

- Delegating the services to The Barnet Group. Although The Barnet Group has a track record as a social care provider organisation, its experience lies in providing social care services, rather than delivering statutory ASC functions of assessment, care and support planning, statutory review, safeguarding, Mental Capacity Act 2005 and Mental Health Act 1983 (amended 2007) Functions, such as Deprivation of Liberty Safeguards. Insufficient synergies have been identified between The Barnet Group and the in-scope ASC services to warrant combining the services. There is also a significant potential conflict of interest arising from Your Choice Barnet's role as a major local provider of learning disability services, sheltered housing and, in the future, extra care sheltered housing. It would be very difficult for The Barnet Group to ensure sufficient separation between the role of assessing social care need and the role of providing social care services to meet those needs. This option also has a less strong financial case than the other three options.

The following options will be taken forward to a detailed options appraisal:

1. **Public service mutual (PSM) organisation**. This option appears to be the most effective way to deliver the required level of cultural and process change at a rapid pace. It also has the strongest financial business case: based upon the preliminary financial modelling, a PSM organisation is the only option that could deliver the project's savings target of £1.96m by 2019/20.

2. **NHS shared service.** The potential benefits arising from integration of health and social care are highly significant. New legal structures for shared services (such as Accountable Care Organisations) are emerging that could increase the attractiveness of this option to the Council. This option has a strong financial case, delivered primarily through efficiencies in contracts with health.

3. **A reformed in-house service**, delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita. This option could deliver the desired cultural and process change, albeit more slowly than could be achieved through other ADMs. This option also has a strong financial case, mostly delivered through a reduction in employee-related costs, realised through reviewing the skills mix of staff, improving staff productivity and increasing the overall efficiency of the service.

7. Next steps

The next stage of this project will be delivered through three workstreams:

1. Producing a further business case that develops each of the three shortlisted options in greater detail, describing how the service would operate; what resources would be required for implementation; timescales for implementation; and how and when savings would be realised.
2. Continuing the work already initiated to prepare for the proposed new operating model through culture and process change (as described in the project methodology on p24).
3. Public consultation on how the new operating model should be implemented and on the proposed shortlist of ADM options.

Based upon the findings from these three workstreams, a preferred ADM will be recommended to the Adults and Safeguarding Committee in September 2016.

	2016						
	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Adults and Safeguarding Committee: consideration of outline business case							
Produce the further business case							
Prepare the new operating model							
Public consultation (12 weeks)							
Adults and Safeguarding Committee: consideration of further business case							

Workstream summary: producing a further business case

Activity	**Product**
Workstream management, including • Co-ordinating workstream activities. • Procuring and managing any external consultancy support required. • Writing the further business case.	• Business case. • Committee paper. • Project management documentation: project plan, risk register, stakeholder communications plan etc.
Carry out research to explore the different ways through which innovative new technology solutions could be implemented.	• Summary of findings that informs the business case.

Activity	Product
Continue to develop the reformed in-house service option.	• Outline implementation plan setting out resources required and how the current service will change.
Identify the actions that need to be carried out and decisions taken to set up and establish a PSM. Estimate the implementation costs and timescales.	• Outline implementation plan setting out resources required for implementation; recommending a governance and legal structure and outlining how the service could grow income over time.
Explore the tax implications (particularly VAT) of creating a new corporate entity separate from the Council.	• Specialist advice on tax implications, and recommendations on the best route to take, including estimated tax liability under new corporate entity.
Engage with local NHS providers to identify potential partners and explore possible implementation priorities and timescales.	• Summary of which potential partners have expressed an interest, and with what terms and caveats.
Model financial costs and benefits of each of the three options, including projected set-up and procurement costs, and net savings projections both for the short term (2017/18 – 2019/20) and the medium-to-long term.	• Detailed financial model setting out costs and benefits of each option.

Workstream summary: preparing for the new operating model

Activity	Product
Workstream management, including • Co-ordinating workstream activities. • Procuring and managing any external consultancy support required. • Ensuring the workstream aligns with the Council's wider ASC transformation programme.	• Project management documentation: project plan, risk register, stakeholder communications plan etc.
Translate the operating model into a detailed set of operational changes and outcomes.	• Summary of the operating model that can be shared with service users, carers, residents and staff.

Activity	Product
Design and facilitate a co-design process, involving service users, carers, residents and staff in the development of the new operating model.	• Specifications for each element of the operating model, describing what changes need to be made, what barriers need to be overcome and the ways in which the service will look and feel different when the operating model has been implemented successfully.
Run staff consultation on the service restructure proposed as part of the new Mental Health Community Model[13] (implementation of these proposals to be integrated with this workstream).	• Consultation documentation • Staff communications.
Implement the changes identified through the co-design process. Monitor and measure the impact of the changes and use this evidence to continually review and refine the changes. (This will become a business-as-usual approach.)	• Baseline data (before changes are implemented). • Data collected and analysed.

Workstream summary: public consultation

Activity	Product
Write the public consultation document.	• Consultation document setting out proposals and consultation questions.
Facilitate consultation event(s) to hear the views of a range of service users, carers and residents.	• Invitations using a range of appropriate channels that reflect the diversity of service users. • Consultation event materials, also reflecting the diversity of service users.
Write up the findings from the public and staff consultations.	• Consultation findings summary document.

[13] See item 8, approved by the Adults and Safeguarding Committee on 16 September 2015: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=698&MId=8360&Ver=4

Project budget

The following project costs are anticipated for April 2016 – September 2016:

Workstream	Costs (exclusive of VAT)
Producing the full business case	• Project management. **c.£70,000.** • External consultancy/professional advisory services to support the workstream activities. **c.£27,000.** • This assumes the project manager will lead the development of the business case, with significant input from Council teams.
Developing the new operating model	• Project management. **c.£70,000.** • External consultancy services to support the workstream activities. **c.£20,000.** • This assumes the Adults and Communities Delivery Unit will lead the development and implementation of the new operating model.
Public consultation	• Additional resource to support Council officers preparing and delivering the public and staff consultations. **c.£10,000.**
Total	**c.£197,000**

Timescales for ADM implementation

The following timescales are anticipated for implementation of each of the ADM options (assuming a recommended option is approved by the Adults and Safeguarding Committee in September 2016):

- **Reformed in-house service:** implementation of the transformation programme (as described in Appendix B) would take approximately 18 months to complete.
- **PSM:** timescales depend upon the implementation approach. For example:
    - In Shropshire, P2P was created with a team of eight staff, voluntarily seconded from the Council, serving only Shrewsbury. P2P's scope expanded over a two year period, growing to 66 staff by the end of the first year and 120 by the end of the second year. Under this approach a PSM could be established in as little as three months and begin operating in December 2016.
    - In North East Lincolnshire, Focus began its operations at full scale. The business case for a PSM was approved in July 2012 and Focus launched 10 months later, running in "shadow form" as part of the

Council for a further 5 months. Under these timescales, a PSM could be established in shadow form by June 2017; launching as a fully independent company in November 2017.

- **NHS shared service:** timescales depend on the shared service model adopted. A Section 75 Agreement with transfer of staff employment could be implemented in approximately 12 months. An ACO model would take longer, as this is a new form of NHS organisation. The Barking & Dagenham, Havering and Redbridge Accountable Care Organisation pilot will plan and assess the pilot over a period of 6-9 months, followed by phased implementation over three years.

All of these assumptions will be tested and explored in greater detail as part of the development of the full business case.

The new ADM needs to start delivering savings from the financial year 2017/18. Therefore under each of the options a phased approach to savings realisation would be required, under which some savings can be realised while implementation of the ADM is still in progress.

Indicative implementation milestones for the shortlisted ADM options

	Sep 2016	Dec 2016 (+3 months)	March 2017 (+6 months)	Sep 2017 (+12 months)	March 2018 (+18 months)	Sep 2018 (+2 years)	Sep 2019 (+3 years)
Transformation under a reformed in-house service	*Transformation programme (underway now) continues*						
Public Service Mutual: rapid mobilisation		● *Launch (limited scope)*	*Extension of scope*				
Public Service Mutual: standard mobilisation			● *Launch (shadow form)*	● *Launch (independent)*			
NHS shared service through Section 75				● *Launch*			
NHS shared service through ACO	*Phased implementation*						

Appendix A: Stakeholder engagement events

Date	Event title	Stakeholder group	# attendees
11 August 2015	Alternative delivery models – your chance to help shape early on	Adults and Communities Delivery Unit staff	12
12 August 2015 (2 sessions)	Adult Social Care Services Workshop	People who use ASC services and their carers; representatives from local CVS groups and service providers[14].	19
29 September 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff from Richmond Fellowship (a mental health charity and service provider).	5
7 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff from the Barnet Centre for Independent Living.	4
13 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Members of Barnet Seniors' Assembly.	12
15 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Staff and members of the Stroke Association (Barnet).	16
27 October 2015	Follow-up meeting from Adult Social Care Services Workshop	Members of Barnet Learning Disability Parliament.	15
3, 4, 5 November (4 sessions)	Alternative delivery model sessions	Adults and Communities Delivery Unit staff.	c.12 at each session
1 December 2015 (2 sessions)	ADM Staff Engagement Sessions	Adults and Communities Delivery Unit staff.	c.25 at each session
9 December 2015	Adult Social Care Services Workshop	People who use ASC services and their carers.	18
10 December 2015	Adult Social Care Services Workshop	Local CVS groups and service providers[15].	11

[14] Representatives from Advocacy in Barnet, Barnet Asian Elders, Barnet Carers Centre, Barnet Centre for Independent Living (People's Choice team), Barnet Seniors' Assembly, Chinese Mental Health Association, Healthwatch Barnet, One Housing Group, Richmond Fellowship, Stroke Association.

[15] Representatives from Advocacy in Barnet, Barnet Asian Elders, Barnet Carers Centre, Barnet Centre for Independent Living, Barnet Mencap, Barnet Seniors' Assembly, Healthwatch Barnet, Kisharon, Mind in Barnet, Richmond Fellowship, Stroke Association.

Appendix B: In-house service transformation programme

Under a reformed in-house service the in-scope services would continue to be delivered by the Council's Adults and Communities Delivery Unit, in partnership with Capita, which provides back office services[16] to the Delivery Unit under the Council's corporate CSG contract.

To deliver the operating model, the following would be required:

More efficient working practices.
The introduction of community hubs instead of home visits to provide assessments and reviews in community locations, and to provide information and advice to help people access support within their communities.

A new case management system is being implemented that will make practitioners' administration and case recording significantly more efficient. This will be enhanced with new mobile devices such as tablet computers that allow for easier working around the borough and can cut down on travel time and duplicate recording.

The new system will be an enabler for changes to performance management. The service will need to adopt a data and insight-driven approach to performance improvement and user and carer outcomes

Front line staff will continue to be part of the Better Care Fund integrated teams as they are rolled out across Barnet.

Opportunities to get greater value from the support services currently provided by CSG will be explored.

Culture change and workforce development.
A continuous improvement culture needs to be developed with positive and proactive practice around risk and decision making, and where staff feel comfortable in giving residents choice and control to take risks. Work will continue to help change the type of conversation held with residents so that not everything has to lead to a full statutory assessment of Care Act eligible needs but rather work is focused on achieving the outcomes users and carers want, and ensuring record keeping is proportionate.

Priorities for workforce development will include embedding an asset-based and solutions-focused approach among all front line practitioners; personal accountability; dealing with difficult conversations and situations; risk assessment and management; and effective mental capacity and safeguarding practice. An ongoing programme of work to improve and assure practice quality will be required.

[16] Finance, ICT, Procurement, Insight, Customer Services, HR, Estates and Health and Safety.

The asset-based approach will be applied to practitioners' work with residents and also to non-customer focused work, to improve problem solving and grow personal accountability.

There will be skill mix changes in operational teams with 17 registered social worker posts being replaced with Assessment and Enablement Officer posts[17]. The service will need to extend its skill mix and productivity improvements further to deliver the agreed service model. It will also need to work on developing the peer support, advice and community/volunteer involvement required to deliver the service model.

Service development.
Work is ongoing to enhance the telecare services provided and in particular to grow the offer to support residential and supported living placements.

The new model for mental health social work is being implemented to grow a social model with emphasis on recovery and community inclusion. This includes a real focus on employment and housing.

Continued implementation of the carers' strategy will include launch of a new service in early 2016 for individuals with dementia and their carers. This will be delivered in-house and support carers to prepare for their caring role.

Improvements are being scoped to the online ASC offer, to increase provision of digital access to services. This will include improving the information and advice provided; providing online self-assessment and editable support plans; utilising the benefits of the new case management system to allow self-service; and creating an online marketplace/management tool for people who receive Direct Payments.

The approach to prevention and initial access to social care will be enhanced. This will include provision of better and broader information and advice; widening the online information available on Social Care Connect; and avoiding contact at crisis point.

The brokerage service will be developed to enhance the Delivery Unit's ability to find creative forms of provision and ensure that the right balance of high quality – good value for money is achieved in making placements.

The enablement model will grow, with particular focus on increasing employment opportunities; growth and promotion of telecare; and service development of the Network model for mental health.

[17] Approved by the Council's General Functions Committee on 18 February 2016.
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=174&MId=8584&Ver=4

Implementing this approach

Implementing this remit will be challenging and will require resource. Much of this will need to come from the business-as-usual structure, with a need to include:

- Coaching for operational managers, with a focus on culture change, motivation and accountability.
- Facilitation of action learning sets and reflective practice sessions.
- Change management capacity including National Graduate Development Programme (NGDP) graduates and other temporary resource.
- Experimentation with new roles, such as community facilitators to prototype different preventative models.
- Back-fill capacity to free up practitioners to develop new ways of working and facilitate co-production.
- Training on topics including asset-based approach, feedback, delegation, challenging conversations and use of community resources.
- Use of the Delivery Unit's in-house policy and improvement team.
- Freeing up management time to focus on delivery of this agenda.

Appendix C: NHS shared service implementation options

Historically, shared services across health and ASC have been implemented in a number of different ways. For example:

- In 2005, Torbay Council delegated its ASC functions to Torbay Primary Care Trust (PCT), under Section 31 of the Health Act 1999, which introduced powers for Primary Care Trusts to exercise various local authority functions and for local authorities to exercise various Primary Care Trust functions. Under this agreement Torbay PCT became Torbay Care Trust and held responsibility for commissioning and providing integrated health and social care services to people in Torbay. As part of the changes associated with the Health and Social Care Act 2012, responsibility for commissioning ASC services was transferred back to Torbay Council in April 2012 (responsibility for delivery of ASC services remained with the Care Trust). The Care Trust was renamed Torbay & Southern Devon Health and Care NHS Trust.

- In October 2015, Torbay & Southern Devon Health and Care NHS Trust merged with South Devon Healthcare NHS Foundation Trust (which ran Torbay Hospital) to form Torbay & South Devon NHS Foundation Trust, the first example of an Integrated Care Organisation in England, providing both acute and community healthcare and ASC services.

- In 2011, Swindon Borough Council and Swindon Primary Care Trust created SEQOL, a single organisation to co-deliver health and social care services in Swindon. SEQOL was created as an employee-owned Community Interest Company (CIC).

- In 2012, responsibility for ASC in Staffordshire was transferred from Staffordshire County Council to Staffordshire and Stoke on Trent Partnership NHS Trust under a Section 75 Agreement[18], with pooled budgets hosted by the NHS Trust. This partnership created the largest integrated health and social care provider in the UK, responsible for community healthcare and ASC across a population of 1.1 million people.

The NHS Five Year Forward View[19] set out a vision for the “next generation” of health and social care integration, in which services are integrated around the person and networks of care, cutting across organisations, are developed. For example:

- In Northumberland, local NHS organisations have joined with Northumberland County Council, local GPs, mental health services and the ambulance service

[18] Section 75 of the National Health Service Act 2006 allows various innovative forms of joint working between NHS organisations and local authorities.

[19] Published on 23 October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

to create a single Accountable Care Organisation (ACO) by 2017. The ACO will be responsible for delivering population-level health and social care outcomes, and will take on the risks around planning and funding services for the population.

- In December 2015 it was announced that the London Boroughs of Barking & Dagenham, Redbridge and Havering would run a pilot to develop an ACO across the three boroughs. Potentially, the new organisation would manage urgent and emergency care, other elements of hospital care, primary and community health services, social care and preventive services.

- In Greater Manchester, 10 local authorities, 12 clinical commissioning groups and 14 NHS partners will take control of the region's £6bn health and social care budget from April 2016. Ultimately the new mayor of the conurbation will assume control over how budgets are allocated for public health, social care, GP services, mental health and acute and community care.

Other innovative delivery models are likely to emerge following the announcement in the Government's Spending Review of November 2015 that each part of the country will be required to develop plans for the integration of health and social care services by 2017, to be implemented by 2020.

Appendix D: Findings from informal market engagement

Conversations and meetings were held with a sample of 11 potential partners and suppliers to test the extent to which these organisations have the appetite and capability to work with the Council to develop and operate the ADM. It was made clear to the organisations taking part in this exercise that it did not constitute any commitment by the Council to undertake any procurement exercise in the future. The exercise included no element of supplier selection or evaluation, and no parties were prejudiced by any response or failure to respond to the invitation. The exercise did not constitute a call for competition to procure anything, and the Council is not bound by any proposals or solutions offered as a result.

The key findings from informal market engagement are:

- **Market appetite:** there is a limited market for these services – there are only a small number of credible organisations who would be interested and able to lead a bid for an opportunity of this scope and scale. Whilst an OJEU procurement notice may identify more organisations that may be interested it remains likely that a procurement would quite soon distil down to a small number of prime contractors with a larger number of subcontractors supporting them. It could be a risk for the Council to go down the route of outsourcing to one lead provider, so innovative approaches such as using lots to develop a “best of breed” model may be a more favourable option.

- **Market maturity:** as the above suggests there is not a mature market for this scope of services. Of the 11 organisations interviewed none have a single contract that covers the full scope that the Council is considering, although some cover elements of the scope across a number of different contracts. Externalising this service would therefore be relatively pioneering. This leads to some risks as the solutions and benefits are unproven, and it is still unclear how the market will respond. However, there are also potential benefits – a provider may be prepared to invest to gain early market share and it may be possible for the Council to agree favourable terms.

- **Potential benefits:** only two organisations were willing to estimate the level of financial benefits - around 20% savings on the 2015/16 budgets, however these were only very rough estimates. These responses suggest that there is potential for savings to be made. However the organisations could not provide evidence of the financial benefit at this stage, which supports the thought that the market may be immature. The ways of delivering financial and citizen benefits were seen as being more prevention work, demand management, efficiency, technology, local market development and more personalised care.

- **Shaping a future contract:** most of the organisations felt that a contractual relationship of between five and seven years would allow up-front investment

return and the time to implement longer term changes. Having sufficient control and including demand management areas was seen as key if outcomes-based targets and risk/reward were required. Effective integration with health was also seen as an important element by most organisations.

- **Engagement with a procurement process:** most of the organisations (10 of the 11 interviewed) said they would probably engage to some degree with a procurement if only to find out more, but with several seeing themselves as being part of a consortium to meet the full requirement rather than leading a bid. This highlights the need for an innovative procurement process that will allow consortia to form, or that will enable the scope to be divided into lots. Although consortia based approaches can bring the advantages of “best of breed” solutions, they can also be fragile – they often involve organisations who have not worked together before and so they may experience problems in establishing effective relationships.

These findings highlight that it may be a risk for the Council to enter such a new and fragile market. Should this option be taken forward, it would be necessary to design an approach that encourages multi-organisation solutions. This would help to obtain the best market response and most effective solutions.

Appendix E: Summary of The Barnet Group's proposal

The Barnet Group was set up by the Council as a Local Authority Trading Company (LATC) in 2012. The Barnet Group is the parent company to two subsidiary companies:

- Barnet Homes, which manages the borough's 15,000 council homes on behalf of the Council and also works to prevent homelessness and allocates homes to social housing applicants.
- Your Choice Barnet (YCB), an ASC company that provides care and support services to adults with learning and physical disabilities.

Under procurement case law (known as the Teckal exemption), the Council can contract with The Barnet Group without going through a competitive procurement exercise. A key requirement for meeting the Teckal test is that the Council exercises decisive influence over The Barnet Group's strategic and significant decisions and that The Barnet Group's trade with customers other than the Council is limited to less than 20% of its total turnover.

Two meetings were held with The Barnet Group to explore its appetite and capability to deliver the in-scope services. The Barnet Group already has a strong working partnership with the Council, and connections with local partner organisations.

The Barnet Group's proposed ADM would focus on prevention and early intervention, providing short-term support to enable people to remain independent, whilst providing appropriate ongoing support for those who need it.

The Barnet Group has indicated that it would set up another subsidiary company through which to deliver the in-scope services, and that the management of this service would be separate from the management of Your Choice Barnet. The ADM would have its own Board. Both Directors would report into The Barnet Group's Chief Executive. In this scenario, extremely robust processes would be required to manage and monitor the risk of conflict between care brokerage (one of the in-scope services) and YCB services.

The Barnet Group's view is that it could deliver savings through:

- Reducing expenditure on Council-funded packages of care and support, by increasing prevention and short term services to enable people to remain in their own homes.
- Exploring peer-to-peer training as a way to spread good practice and encourage practitioners to identify alternatives to traditional Council-funded care and support.
- Employing new employees through The Barnet Group's employment vehicle, TBG Flex.

- Changing the skill mix of front line staffing, with increased numbers of Assessment Officers.
- Streamlining processes, including the development of automated processes.
- Extending the use of telecare equipment and IT software.

Based upon its experience of taking over the management of YCB and Housing Options services, The Barnet Group recommends a phased approach to transition over a two-to-three year period, in order to minimise risks to service delivery while delivering efficiency improvements.

Appendix F: Public service mutual (PSM) research

Features of a PSM

- It delivers public services.
- Any profits it generates are re-invested in the service.
- It is independent of the Council, has a high degree of control over its future, can innovate, grow rapidly and generate additional income.
- It can have a number of different ownership structures, for example:
    - 100% owned by the PSM staff.
    - Jointly owned by the PSM staff and the local community.
    - Jointly owned by the PSM staff and the Council.
- Its strategic direction is set by a management board, the membership of which reflects the PSM's ownership structure.

The PSM could take a number of different legal forms. In recent years the most popular form for these types of organisation has been a Community Interest Company (CIC), but other forms such as limited companies or community benefit societies have also been used. Under some legal forms, the PSM could be a charity or have charitable status.

Choice of legal form depends upon the strategic and operational priorities of the PSM. For example: preferred governance arrangements; the extent to which it wants to trade; the extent to which it wants to fundraise and apply for charitable grants; and the importance of "locking in" the PSM's assets for the benefit of the community.

Findings from research into PSM organisations

Focus in North East Lincolnshire was the only one of the Department of Health's Social Work Practices with Adults pilot sites that took responsibility for all professional social work (except mental health services) at its inception. ASC services moved from the local authority to a NHS care trust in 2011, and professional social work was then delegated to Focus in 2013.

Barnet's project team researched Focus and then spent a day with Focus' senior leadership team in September 2015. They heard that the service has streamlined its day-to-day activities by removing non-statutory Council processes and procedures. Decisions can be made much more quickly. Staff feel they have greater freedom to be creative in the way they work and this shows in higher levels of staff engagement and reduced sickness absence rates, from approximately 8-9% to 2-3%.

Focus is a staff mutual organisation, which means it is owned by its employees. All permanent members of staff can pay £1 to buy a share in the organisation, and 92% of employees have taken up this opportunity. Employees also make up a majority on

Focus' management board. Staff feel strongly that Focus is "their" organisation and they are very proactive in working to develop the service further and ensure its ongoing success. Since becoming a PSM there has also been a shift from staff being quite "institutionalised" and focused upon the internal workings of the service, to staff being much more outward-looking and building stronger relationships within the wider local community.

In 2014 Focus formed two subsidiary companies: Focus Solutions, which provides ICT systems and consultancy support to local authorities, and Focus Independent Professionals, which offers social work staffing solutions. These companies are still in the early stages of development but over time they are expected to generate profit that can be re-invested into the service.

Focus noted that it would be easy to underestimate how much work is involved in establishing a new organisation. Actions such as setting up a bank account, registering to pay VAT, appointing accountants and obtaining insurance can all be complex and time-consuming, particularly so when the new organisation is not a conventional, straightforward business operation. It is also important to consider carefully how much strategic ASC expertise needs to remain within the Council.

In November 2015 the project team also visited People2People (P2P) in Shropshire. P2P was created because although many improvements were being made to the Council's ASC services, those improvements were not being implemented effectively. The ASC senior management team thought there could be much more improvement, more quickly, if the service was delivered outside of the Council.

P2P rented accommodation outside of a Council building, in order to make a clear statement to staff and people using the service that it was not part of the Council. Staff got the new accommodation ready themselves. At first it was a shock to staff that the Council wasn't going to sweep in and get everything ready for them, but this sent a powerful signal to the public and staff about P2P's independence from the Council, and started to create a strong sense of ownership and pride amongst the staff in "their" service. Like Focus, P2P is a staff-owned mutual organisation.

P2P believes the PSM model will be successful if staff really want it to happen. There has been some staff attrition since P2P was established, as some staff who did not support the model left, but this means that those staff who remain really understand and believe in what P2P stands for.

Initially some local community and voluntary sector groups were suspicious of P2P and some saw it as an attempt by the Council to encroach on "their" territory. However, these groups now see P2P as "one of us" and are keen to collaborate with P2P and work together on joint initiatives and funding bids.

Across both P2P and Focus there was acknowledgement that the barriers to change in an in-house service were almost always cultural and behavioural. Staff had got into the habit of saying “the Council wouldn’t let us do that”. When the Council was no longer running the service, staff felt they had greater power to innovate and make improvements.

Service development opportunities that could be explored under a PSM

- Reforming the enablement service, with a home carer workforce development plan to increase skills around behaviour changes and use of equipment and preventative services. Over time this service could expand into the delivery of intermediate care services on behalf of the CCG.
- Exploring opportunities to trade in services such as staff training and development, telecare, recruitment and support of personal assistants, health and social care analytics, and retailing adaptations, equipment and electronic aids.
- Co-production of services with staff and service users, and developing a recruitment strategy to increase the proportion of the workforce with lived experience of social care services.
- Developing an in-house volunteering programme and partnering with CVS organisations to develop new ways of delivering services.

Appendix G: Equalities

Equalities impact of the proposed new operating model

An initial equalities impact assessment (EIA) of the proposed new operating model was completed in October 2015 and included as part of the strategic outline case presented to the Adults and Safeguarding Committee on 12 November 2015[20]. The EIA showed "impact unknown" for staff and "no impact anticipated" for residents and service users. This EIA was reviewed by the lead officer in February 2016 and no requirement to update it was identified. The EIA for the proposed new operating model will be reviewed again following public consultation on the proposed new operating model.

The profile of the protected characteristics of ASC service users and Adults and Communities Delivery Unit has not changed materially since its publication in the strategic outline case in November 2015.

Equalities impact of the shortlisted ADM options

The ADM options have been evaluated on the basis of the extent to which they fulfil the options appraisal criteria agreed by the project board, as described in section 6. The options of outsourcing/JV with a partner outside the public sector and delegation of services to The Barnet Group will not be considered further because they were the weakest options when judged against these criteria. The potential equalities impact of these options has therefore not been considered.

The three shortlisted options are unlikely to have an equalities impact upon ASC service users because all three options are structures through which the proposed new operating model would be delivered. However, not enough is yet known about how the ADM options would be implemented to say for certain that the choice of ADM will not have an equalities impact upon service users. Therefore the potential impact on service users will be reviewed prior to submission of the further business case in September 2016.

The ADM options will affect Adults and Communities Delivery Unit employees, with reference to which organisation employs them and potentially their terms and conditions of employment and their job roles. However, not enough is yet known about the ADM options to be able to say what the equalities impact would be under each option; which staff would be affected and in what ways they would be affected. Therefore the potential impact on employees will also be reviewed when the three shortlisted options have been developed in greater detail as part of the development of the further business case.

[20] See Appendix C: Equalities.
http://barnet.moderngov.co.uk/documents/s27172/Appendix%20A%20Strategic%20outline%20case%20for%20a%20future%20operating%20model%20for%20adult%20social%20care.pdf

Appendix H: Health and Safety

An initial assessment of Health and Safety risks associated with the proposals has been carried out. This has identified that there are no additional Health and Safety risks beyond those normally associated with the delivery of these services and which are managed through the established Health and Safety policies and procedures. An assessment of the possible Health and Safety risks associated with the community hubs pilot has been carried out separately by the hubs pilot project team.

In the event of a third party or separate organisation being established, there will need to be due consideration of Health and Safety matters in the commissioning process.