APPENDIX B

Public Health Devon

Devon County Council

Future provision of the 0-19 Public Health Nursing Services for Devon for April 2019

Options Analysis

Contents

1.0 Introduction

1.1 At the Devon County Council Cabinet meeting, held on the 11th October 2017, the Cabinet approved the undertaking of an option appraisal for the provision of the 0-19 Public Health Nursing Service, Portage and ROVICs services from April 2019 onwards.

1.2 This document describes the different options for the future provision of the 0-19 Public Health Nursing Service (PHNS) for the footprint of Devon County Council. It builds on four pieces of preparatory work undertaken when considering the provision of services for 2018-2019 as an interim contract;

- the options appraisal which informed Dr Virginia Pearson's report to Cabinet on 8th March 2017(http://democracy.devon.gov.uk/ieListDocuments.aspx?CId=133&MId=184&Ver=4).
- The consultation on the future procurement and delivery of Public Health Nursing Services, undertaken between January – March 2017.
- The Best Alternative To Negotiated Agreement (BATNA), jointly produced between Children's Social Care and Public Health following Cabinet's decision to agree a Section 75 Agreement with NEW Devon CCG when considering the interim contract offer being made to Virgin Care Ltd for 2018-19.
- The jointly commissioned consultation on Community Health and Wellbeing Services for Children and Young People in Devon, undertaken between July – September 2017.

1.3 The options fall into 2 broad categories:

1. **Procurement of the PHNS**
2. **DCC direct delivery of the PHNS**

Within each of the categories 2 options are considered:

Procurement of the PHNS

1a: Open procedure with one contract;
1b: Procure a joint venture delivery vehicle

DCC direct delivery of the PHNS

2a: 'In-house' as a department of DCC.
2b: Placing all activity relating to the PHNS into a wholly owned subsidiary of DCC;

1.4 Public Health Nursing is a mandated service directly funded by the Public Health Grant, which the local authority receives from the Department of Health. The service forms part of the Director of Public Health's responsibilities for 'any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations – these include services mandated by regulations made under section 6C of the NHS 2006 Act, inserted by section 18 of the 2012 Act'

Therefore, there is no possibility of a "do nothing" option with regard to providing a Public Health Nursing Service, hence such an option has not been considered.

1.5 All the options are analysed to a set of assumptions which remain, irrespective of the option that is determined to be the preferred option. These are:

- The specification for the PHNS is based upon the national template 0-19 Healthy Child Programme.
- The budget (£10million per annum) for the service does not alter.
- Identification of core public health nursing staff who are likely to be eligible for TUPE will be relatively straightforward however obtaining a full TUPE transfer list from the current incumbent will require a longer time period so some assumptions have been made on the staffing requirements.

1.6 All options are presented in the same format:

Section A: Brief description of the model
This describes the main features of the option.

Section B: Key Features
This outlines the key features underpinning the option.

Section C: Ability to achieve the objectives
Critical strategic objectives for the delivery of the Public Health Nursing Service in Devon have been devised, and in this section each option is considered against each objective.

Section D: SWOT analysis
This looks at the strengths, weaknesses, opportunities and threats of the options.

2.0 Background

2.1 Ensuring that Devon's children and young people have the best start in life, and grow into healthy adults, is one of Devon County Council's top strategic priorities and a priority for the partnership of the Wider Devon Sustainability and Transformation Programme (STP). Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status.

2.2 The current 0-19 population in Devon is 162,000, with approximately 7,000 - 7,500 new births per year although there is some variation year to year. A gradual increase is predicted over the next 20 years.

2.3 The overall purpose of the Public Health Nursing Service is to contribute to the improvement in the health and wellbeing that support all children and young people, to keep children and families safe, and reduce health related risks across the life-course. This is achieved through delivery of mandated (legally-required) universal public health assessments and undertaking public health interventions designed to offer prevention

that supports families to adopt healthy lifestyles and identify and address difficulties and issues as early as possible. The service therefore has a significant role to play in early help.

2.4 Public Health Nurses work with other agencies to provide additional support to children, young people and families at the earliest opportunity where longer-term intervention is needed. Resources are focused on the most deprived geographical communities and communities of need within Devon to improve their health outcomes while offering a universal service to all children who are residents of Devon, plus those who attend Devon schools and academies. Current service provision and health outcomes for children compare well in Devon to other areas, despite recent national concern about trends in the health and wellbeing of children.

2.5 Providing the full range of Public Health Nursing Services (0-19 years) has been a statutory responsibility of Devon County Council since October 2015 when 'A Call to Action 2011,' a national programme to deliver on the Government's commitment to increase the number of health visitors by 4,200 by March 2015 and to transform services, resulted in the transfer of the Public Health 0-5 commissioning from NHS England to Local Authorities. Public Health Nursing is subject to a National Specification and charged with leading the delivery of the Healthy Child Programme 0-19. A large part of the delivery includes 5 health reviews, beginning pre-birth, and the delivery of the National Child Measurement Programme (NCMP) all of which are mandated by law. This mandate has been extended for the 'foreseeable future'.

2.6 The Government's intention in transferring the responsibility for the Public Health Nursing Service to the local authority as part of the public health transition arrangements was to ensure that local authorities were able to better align their social and health care responsibilities for children, young people and families.

2.7 Since 2013, the Public Health Nursing Service has been delivered as one of three community health and care strands within the 'Integrated Children's Services' joint contract. The contract is co-commissioned between NEW Devon CCG, SD&T CCG, NHS England and, from Devon County Council, Public Health and Children's Social Care. The current arrangement is that the contract management and administration is provided by NHS NEW Devon CCG as 'host commissioner'. The contract ceases on the 31st March 2019. The CCG are currently undertaking a re-procurement exercise for the NHS services for which they have commissioning responsibility.

3.0 Strategic Objectives

3.1 A set of strategic objectives for the delivery of the Public Health Nursing Service in Devon has been devised.

3.2 **Strategic Objectives**:

1. To ensure Devon residents have open access to a high quality 0-19 Public Health Nursing Service:
   - services are compliant with national clinically recognised standards.
   - there are clear mechanisms for quality assurance.
   - governance processes are robust/fit for purpose.

2. To ensure Devon has an effective Healthy Child Programme and an integrated system, in which all service providers, commissioners and stakeholders work

collaboratively to ensure services are evidence based and promote positive child health for its population and improve children and young people's health outcomes.

3. To ensure that the process for the re-provision of the PHNS does not adversely affect service quality and access.

4. To ensure the PHNS is capable of delivering the outcomes detailed within the service specification within the available DCC Public Health Grant allocation.

5. To ensure that the service delivery model aligns with the strategic vision for the Local Authority (Best Start in Life).

6. To ensure that the PHNS is agile and responsive so it is capable of flexing and adapting to changing future needs. This includes the ability to react quickly and adopt new, more efficient ways of working effectively in a timely manner such that best value for money is achieved on an ongoing basis, whilst continuing to drive up quality.

Option 1a: Procurement of the Public Health Nursing Service

Section A: Summary

Description
This option considers the procurement of a PHNS by DCC. The PHNS would be specified as a standalone service whilst recognising the landscape of children's services and indicating links and pathways to ensure an integrated system from a user's perspective. The procurement would be led by the DCC procurement office, the contract awarded would be a DCC Public Health contract. The contract would be a 'block contract' and so would not exceed the budget available. Market engagement, consultation and warming events would be undertaken independently of those for the other Community Health & Wellbeing Services for Children and Young People. Through considering this option, the greatest focus could be given to the particular 0-19 agenda to ensure that the specification is fully informed by feedback from the market warming, consultation and engagement events. The engagement and market warming events would help inform any service Lots.

Section B: Key Features

Structure
The structure would be dependent on how the PHNS was procured and on the results of the procurement exercise.
HR features
TUPE would apply to all service transfers.
Legal features
This would be a standard procurement exercise run by DCC's in house procurement office. The contract placed would be the standard DCC/PH contract as designed for these purposes.
Financial features
The budget associated with running this service would be separately identified as part of the Public Health Grant. This would be a committed contract spend for the life of the contract and ensure direct and appropriate use of DCC Public Health Grant allocation to fund the contract for services.
Procurement features
It is intended that this would be a standard open tender procurement, for contract award in Autumn 2018 and a new service going live on the 1st April 2019. Devon County Council procurement office would manage the procurement. Two indicative timescale planners have

been attached (Appendix A & B). One option is a single stage procurement, whilst the other allows for an element of negotiation.
Timescale and achievability
The procurement timescale is currently achievable due to the preparatory work already undertaken developing the specification. Delivery within the timescale is dependent on a decision being made early in 2018 and receipt of all the key tender prerequisites such as TUPE lists and property packs, etc.
Other Considerations
As the time-line corresponds to that of the rest of Community Health & Wellbeing Services for Children and Young People, re-procurement, care would need to be taken to avoid a market 'gridlock' with providers trying to service different but proximate timelines and processes. This would require good communications with other commissioners to ensure no clashes of timing, but without the need for a formal alignment. The alignment of procurement timescales provides an opportunity to ensure that the future overall service model and system for health and care services for children and young people are coordinated and aligned.

Section C: Ability to Meet Objectives

Objectives	Ability To Meet Objectives	Score (1-10)
To ensure Devon residents have open access to high quality Public Health Nursing Services: • services are compliant with national clinically recognised standards • there are clear mechanisms for quality assurance • governance processes are robust/fit for purpose.	Fully able to meet these objectives which will be specified. Known market for the delivery of this service. A direct contractual arrangement dealing with only the PHNS service would allow greatly visibility and control of the service across the full term of the contract, as there would be no ability for funds from the commissioner to be used to underpin other areas of children's services. Also, commissioner/provider relationships could be built to be strong as this would be a direct relationship. Public Health has a track record of good relationships with providers in directly procured services.	10
To ensure Devon has an effective Healthy Child Programme and an integrated system, in which all service providers, commissioners and stakeholders work collaboratively to ensure services are evidence based and promote positive child health for its population and improve children and young people's health outcomes.	The commissioners would expect to work with commissioners and service providers from the wider areas of the system to ensure collaboration and an integrated system.	8
To ensure that the process for the re-provision of the PHNS does not adversely affect service quality and access.	Providing absolute clarity on both the budget and the service specification will support the best possible re-commissioning process. Good working relationships with the NHS and DCC colleagues should act to mitigate any negative impacts. There is a high degree of confidence of achieving this option within the timescale and the impact to the workforce and service users will be minimal.	8
To ensure the PHNS is capable of delivering the outcomes detailed within the service specification within the available DCC Public Health Grant allocation.	This option is guaranteed to come within the contract budget and there will be assurance of the direct and appropriate use of DCC Public Health Grant allocation in accordance with the requirements of the Grant determination. A direct commissioner/provider relationship should enable a direct focus on the PHNS.	9

	This would ensure sustainability of the service and the ability to maintain the PHNS workforce.	
To ensure that the service delivery model aligns with the strategic vision for the Local Authority (Best Start in Life).	A direct commissioner/provider relationship should enable this to happen. Through the procurement process DCC will ensure that the delivery model will align to the strategic vision with the contract setting out clear and precise contract review clauses which will highlight the scope and nature of possible variations and these will not alter the overall nature or scope of the contract. There will still need to be an expectation that it may take time to react to new ways of working and reach agreement with the provider to possible variations.	7
To ensure that the PHNS is agile and responsive so it is capable of flexing and adapting to changing future needs. This includes the ability to react quickly and adopt new, more efficient ways of working effectively in a timely manner such that best value for money is achieved on an ongoing basis, whilst continuing to drive up quality.	The direct commissioner/provider relationship should allow the service to be reactive to change, able to adopt enabling technologies as they appear and able to drive maximum quality and efficiencies out of the budget. The contract will need to set out clear and precise contract review clauses which will highlight the scope and nature of possible variations and these will not alter the overall nature or scope of the contract. Ensuring the need for maximum flexibility would need to be described at the procurement stage such that the provider works alongside DCC to enable change. It does rely on the strength of the relationship and may take time to react to new ways of working if contract variations are required.	7
	TOTAL	49

Section D SWOT Analysis

Strengths	Weaknesses
• **Financial Risk -** Will ensure the requirements of the financial envelope are met as the budget will be defined as part of the tendering process. • **Clinical Governance –** Provider would have all the necessary governance requirements, such as CQC registration, clinical governance processes, clinical supervision and any related additional liabilities that (such as insurance requirements). • **Will ensure direct and appropriate use of Public Health Grant** monies, in accordance with the requirements of the Grant determination. • **Direct relationship between budget and service** - enables full control of the budget through the life of the contract. • **Workforce –** The impact on the staff, including potentially leaving the service, is likely to be less than the other options to leave the service as this option was more favourably received in the earlier consultation. • **Branding -** Enables branding to be separate from DCC and to have a potential clear alignment with “health” services	• **Responsiveness**: If contract variations are required due to unforeseen circumstances the commissioners will need to agree any such variation with the provider which could delay or reduce responsiveness, incur additional costs and reduce flexibility to service delivery.
Opportunities	**Threats**
• **Social value-** encouragement of formation of consortia or sub-contracting arrangements could potentially open up smaller/local organisations participation and could harness multiple providers expertise.	• **Legal challenge-** risk of legal challenge is very low if meaningful consultation takes place before the procurement process starts and the procurement process is followed correctly.

• **Vertical Integration-** there is a potential that responsibilities may sit with one Provider and there is an opportunity to pilot outcome measures across a local geography in this type of arrangement. • **Wider range of providers –** smaller lots for smaller services could enable a wider range of specialist providers to enter the market.	

Option 1b: Procurement of a Joint Venture delivery vehicle

Section A: Summary

Description
This option considers an approach of procuring a joint venture delivery vehicle whereby DCC will work with another organisation to deliver the PHNS which may be from the public sector or the private sector. Joint ventures are arrangements between a minimum of 2 parties, and offer local authorities the opportunity to deliver services with a partner who brings skills and expertise to the partnership that the local authorities do not possess. The partnership can manifest in a number of ways but most likely would be delivered through the creation of a special purpose vehicle (SPV) jointly owned and controlled by the member/owner partners. The contract for the delivery of the PHNS would be between Devon County Council and the new joint venture organisation. This option would rely on a 'lift and shift' of most of the existing workforce (c 170- 200wte). This option would put DCC in shared control of the PHNS and provide an opportunity to align the service with other children's and family services it provides/commissions, as well as alignment with the delivery of wider children's services within Devon.

Section B: Key Features

Structure
At the outset it would be up to DCC to determine the best structure for the SPV and ownership split but the organisation could be for profit or not-for profit, limited by shares or guarantee and could be a Community Interest Company. The structure would reflect the future strategic direction of the Authority. The partner would be expected to bring expertise and knowledge in relation to the many areas of the PHNS that DCC has no experience in delivering, including clinical governance and clinical supervision and CQC registration. Such technical aspects could remain within the scope of the SPV without the complexity of dealing with these issues across only part of DCC operations.
HR features
TUPE would apply to all service transfers. Staff transferring into the SPV would be on the same terms on which they are engaged with VCL be that historic terms and conditions from a previous TUPE transfer or the terms and conditions that have applied as recruited by VCL. If additional staff are appointed to the SPV it is likely they will need to be on the basis of equal pay between SPV employees and DCC employees. However, this does depend on the exact set up of the SPV.

If the set up enables the recruited of additional staff to be on different terms and conditions to those offered currently by DCC this could be advantageous, especially if the service is to be re-tendered in the future. Placing DCC staff out into the market place through later out-sourcing can be expensive to new providers and certain arrangements often continue to be under-written by DCC creating long term liabilities for the Authority.

There may be a need for additional staff e.g. for provision of clinical governance, however, this requirement could be delivered through an arrangement with the joint venture partner whereby the governance is delivered to the SPV through expertise bought from the partner without the need to create additional headcount. If there was any permanence or regularity to this arrangement then TUPE may apply.

Legal features

There would not appear to be any legal obstructions to this option.

The essential aspects of the tender would be clearly set out by DCC. This would include matters such as ownership splits and responsibilities of the parties including governance.

The holding in the SPV would determine the split between the partners regarding risks and rewards as partnerships are not necessarily equal i.e. 50:50. Exact arrangements regarding other elements relating to governance and wider responsibilities would be subject to negotiation and could be difficult and complex.

Financial features

The contract for the delivery of the PHNS would be placed with the SPV following the procurement. The contract would be specific about the budget, how payment is earned and would satisfy the Public Health Grant determination as all spend would be 100% traceable to the Authority.

The SPV would have a different taxation regime from that of DCC, in relation to corporation tax and VAT. Corporation tax may be payable on any “profits” created by the SPV, and the transfer pricing for any services bought by the SPV from either partner would need to be given due consideration to ensure the transfer is at cost and does not give rise to taxation or state aid issues for either parties.

There would be immediate costs (internal & external) relating to the setting up of the SPV as well as ongoing additional costs relating to the financial reporting regime as described above.

Procurement features

The partner would be procured through a competitive dialogue process (CDP) led by DCC’s procurement office.

The process of Competitive Dialogue enables the buying organisation and market to bring together their knowledge and expertise to develop solutions to deliver specific outcomes. When compared to a fixed tender approach the iterative two-way dialogue (between buying organisation and provider(s)) allows for greater co-production, scrutiny and commitment.

Timescale and achievability
Procuring through a CDP process is a longer process than a straightforward procurement exercise. It would take additional time to set up joint entities and there would be more negotiation required as part of the process. The process would require additional resource from programme management, HR, Finance, Legal and external expertise during the preparation and at the time of transition. It is anticipated that this process would require over 12 months so is not likely to be achievable within the deadline of April 2019.
Other Considerations
This option provides the opportunity for the PHNS to align closely with other children's services both within DCC and potentially outside of DCC, depending on the partner, with more direct control than a procured service due to the share of the partnership owned by DCC. The SPV would have its own Board which would be directly accountable to both partners. If the partnership is structured correctly from the outset, the opportunity for other partners to join could be kept open, and/ or other services to be placed within the activities to be delivered by the partnership.

Section C: Ability to Meet Objectives

Objectives	Ability To Meet Objectives	Score (1-10)
To ensure Devon residents have open access to high quality Public Health Nursing Services: • services are compliant with national clinically recognised standards • there are clear mechanisms for quality assurance • governance processes are robust/fit for purpose.	DCC's lack of experience and expertise in delivering a PHNS, CQC registration and providing clinical governance and clinical supervision to a large clinical workforce would be overcome by ensuring that the partner brings these abilities and knowledge.	9
To ensure Devon has an effective Healthy Child Programme and an integrated system, in which all service providers, commissioners and stakeholders work collaboratively to ensure services are evidence based and promote positive child health for its population and improve children and young people's health outcomes.	The PHNS element of HCP would be fully supported through this option due to the direct lines of accountability and a direct commissioner / provider relationship.	8
To ensure that the process for the re-provision of the PHNS does not adversely affect service quality and access.	The transition would need to be very well planned, managed and implemented to ensure that there was no disruption as with any transfer of services between providers. However, the partnership would be with an organisation bringing considerable skills and knowledge and would support DCC whilst ensuring DCC remains in considerable control at all times. This option is not considered achievable due to the procurement process timescales. DCC would need to take great care to minimise the impact to the workforce and service users through loss of staff morale and confidence as the professional framework supporting nursing staff would need to be satisfactorily replaced.	1
To ensure the PHNS is capable of delivering the outcomes detailed within the service specification within the available DCC Public Health Grant allocation.	This option is guaranteed to come within the contract budget and there will be assurance of the direct and appropriate use of	8

	DCC Public Health Grant allocation in accordance with the requirements of the Grant determination. DCC would be able to have direct input into the service as required. There may be options for greater linkages with co-dependent services within DCC e.g. information sharing could become easier. The current financial plans indicate that in the medium term the service could be delivered within the available budget. There would be set-up costs, which would need to be funded from outside the contract value, relating to the creation of the SPV and the negotiation if CPN (Competitive Procedure with Negotiation) and subsequent agreement of all terms and conditions forming the Memorandum and Articles of Association relating to the constitution and governance of the JV. The duration of the contract period may need to be longer than that which might be more common in our standard procurements.	
To ensure that the service delivery model aligns with the strategic vision for the Local Authority (Best Start in Life).	This option provides a good opportunity to align DCC's social and health care responsibilities for children, young people and families as well as the ability to work with other stakeholders and market providers through having some distance from the internal workings of DCC.	8
To ensure that the PHNS is agile and responsive so it is capable of flexing and adapting to changing future needs. This includes the ability to react quickly and adopt new, more efficient ways of working effectively in a timely manner such that best value for money is achieved on an ongoing basis, whilst continuing to drive up quality.	The service could be more responsive as there would be more direct commissioner/provider relationship, should change be needed. Also, there would be an element of market competition, best value for money maybe more likely better achieved than through an in-house option, and external commercial acumen could be brought through the JV partner. A JV would allow DCC the significant levels of responsiveness and flexibility to make changes relatively quickly and easily in relation to budget, service demands and changes e.g. in technology that could achieve efficiencies for the service.	8
	TOTAL	42

Section D SWOT Analysis

Strengths	Weaknesses
• **Financial Risk -** Will ensure the requirements of the financial envelope are met as the budget will be defined as part of the tendering process. • **Allows for** DCC to benefit from the expertise and knowledge that is brought to the partnership from the partner. • **Clinical Governance -** Allows for the specific requirements, such as CQC registration, clinical governance, clinical supervision and any related additional liabilities that (such as insurance requirements) to be "ring-fenced" within the SPV and not related to DCC as a whole. • **Will ensure direct and appropriate use of Public Health Grant** monies, in accordance with the requirements of the Grant determination. • **Direct relationship between budget and service** - enables strong control of the budget through the life of the contract. • **Branding** - Allows service specific branding. The joint venture could be branded as a "health" service which would improve staff morale and enable the clarity required by both staff and service users between this and social services. • **Recruitment** - If additional staff are appointed to the SPV it is likely they will need to be on the basis of equal pay between SPV employees and DCC employees. However, this does depend on the exact set up of the SPV which could allow for recruitment on different T&C's to standard DCC employee's.	• Setting up a joint venture will have additional immediate costs and there will be costs associated with the reporting and regulation of the organisation (relating to e.g. tax compliance, VAT, audit and financial regulation) on an ongoing basis. • Negotiations relating to the exact arrangements for the joint venture could be difficult and would also require DCC resource. • DCC would still need to contract manage the arrangement, so no savings would be released at a corporate level. • **Workforce –** There may be an impact on the staff, including individuals potentially leaving the service. • **Timescales** - Procuring through a CDP process is a longer process than a straightforward procurement exercise and is not considered achievable within the timescales.

This could enable an easier transition in the future to a fully out-sourced position if that becomes necessary/desired.	
Opportunities	**Threats**
• **Social value-** opens up the possibility of contracting with locally based providers of similar services • Additional services could be added to the JV at a later date. • Ability to flex and adapt in a relatively short time is more easily achievable due to the partnership arrangement.	• **Legal challenge-** risk of legal challenge is very low if meaningful consultation takes place before the procurement process starts and the procurement process is followed correctly

Option 2a: DCC direct delivery of the PHNS ('In House')

Section A: Summary

Description
This option considers an approach of not procuring PHNS as a separate contract, but bringing the management, delivery and employment for the PHNS service directly within the remit of the County Council, similar to the approach used for the majority of the delivery of Children's Social Care. This option would rely on a 'lift and shift' of the majority of the existing workforce (c 170-200wte). This option would put DCC in direct control of the PHNS and provide an opportunity to align the service with other children's and family services it provides/commissions.

Section B: Key Features

Structure
It would be up to DCC to determine the best structure for delivery of the service, but this could take place over a number of years, and would not need to be predetermined. There are regulatory issues in relation to clinical governance and CQC registration which will need to be carefully considered and addressed as the Local Authority structures are not designed at present to be deliverers of clinical services.
HR features
TUPE would apply to all service transfers. Staff transferring into DCC would be on either NHS terms and conditions, or the terms and conditions that have applied as recruited by VCL. DCC already has Admitted Body status which enables the provision of NHS pensions. There will be some additional workforce required, to provide the necessary skills and capacity particularly in relation to the provision of appropriate clinical leadership and the required governance infrastructure.
Legal features
If DCC follow due process there would not appear to be any legal obstructions to this option.
Financial features
The service costs and budgets associated with this would be run in the same way as other service costs within DCC. Resource will be required within central functions e.g. finance, estates, ICT, HR, legal, senior operational staff, etc, to provide the necessary back office functions to provide the PHNS. Service delivery would need local bases, and these would need to be resourced by dedicated DCC personnel.

It is unlikely that there would be any significant difference in costs in the medium term, but there would be additional one-off transitional costs incurred during the mobilisation phase and at the time of transfer. Ensuring traceability of service spend will need to be considered to ensure to enable assurance and accountability for the Public Health Grant conditions.
Procurement features
No procurement process would be required.
Timescale and achievability
All timings are within the power of DCC to achieve. Additional resource from programme management, HR, Finance, Legal and other business support services as well as external expertise will be required in preparation for and at the time of transition. The deadline of April 2019 is considered achievable.
Other Considerations
This option provides the opportunity for the PHNS to align closely with other children's services without the need for contractual negotiations and variations.

Section C: Ability to Meet Objectives

Objectives	Ability To Meet Objectives	Score
To ensure Devon residents have open access to high quality Public Health Nursing Services: • services are compliant with national clinically recognised standards • there are clear mechanisms for quality assurance • governance processes are robust/fit for purpose.	DCC currently has no relevant clinical governance structures or processes in place. Additionally, DCC does not currently have a mechanism for adhering to CQC requirements. These can be mitigated by ensuring the early appointment of experienced and skilled staff to develop mobilisation plans and lead the transition of the service within the timescale in order for Devon to have a PHNS, which delivers this objective.	8
To ensure Devon has an effective Healthy Child Programme and an integrated system, in which all service providers, commissioners and stakeholders work collaboratively to ensure services are evidence based and promote positive child health for its population and improve children and young people's health outcomes.	The PHNS element of HCP would be fully supported through this option due to the direct lines of accountability. There would be no need for a commissioner/provider relationship. However, other NHS-based elements of the Healthy Child Programme may be more difficult to engage if PHNS clinical governance is perceived to be weaker. Having the necessary governance infrastructure in place at an early stage will help mitigate this and help achieve this objective.	7
To ensure that the process for the re-provision of the PHNS does not adversely affect service quality and access.	The transition would need to be very well planned, managed and implemented to ensure that there was no disruption. This option is considered achievable within the timescales. However, this option would result in considerable change to the workforce and substantial reassurance of clinical staff would need to be provided to achieve a smooth transfer. DCC would need to take great care to minimise loss of staff morale and confidence as the framework supporting nursing staff would need to be satisfactorily replaced. The early appointment of experienced clinical leadership and early engagement with the current workforce will help	6

To ensure the PHNS is capable of delivering the outcomes detailed within the service specification within the available DCC Public Health Grant allocation.	This option provides DCC with the ability to directly control the service delivery and to achieve the necessary outcomes. Internal mechanisms will need to be put in place to ensure that there is clear oversight and assurance of the direct and appropriate use of DCC Public Health Grant allocation in accordance with the requirements of the Grant determination. There may be options for greater linkages with co-dependent services within DCC e.g. information sharing could become easier. The current financial plans indicate that in the medium term the service could be delivered within the available budget. However, it is expected that during the mobilisation phase of the service additional resources will be required to ensure DCC has the necessary leadership capacity and capability to ensure a smooth transition.	8
To ensure that the service delivery model aligns with the strategic vision for the Local Authority and the STP (Best Start in Life).	This option provides a good opportunity to align DCC's social and health care responsibilities for children, young people and families.	9
To ensure that the PHNS is agile and responsive so it is capable of flexing and adapting to changing future needs. This includes the ability to react quickly and adopt new, more efficient ways of working effectively in a timely manner such that best value for money is achieved on an ongoing basis, whilst continuing to drive up quality.	The service would be more responsive, with fewer layers i.e. there is no commissioner/provider relationship and no contractual obligations to vary etc., should change be needed. But without market competition, best value for money may not be achieved and innovation/input direct from the market may also not be identified at such an early stage. An in-house service would allow DCC the significant levels of flexibility with regard to making changes relatively quickly and easily in relation to budget, service demands and changes e.g. in technology that could achieve efficiencies for the service. Budget reductions can be most easily implemented within in-house services, meaning that future changes in political direction could impact most immediately on PHN services.	10
	TOTAL	48

Section D SWOT Analysis

Strengths	Weaknesses
• **Clarity of management** - performance reporting for DCC services would be straight to Chief Officers • **Alignment -** Increased opportunity to align DCC's social and health care responsibilities for children, young people and families. • **Responsiveness** – the service could respond quickly to changing needs and service demands. • **Autonomy** – this option allows for more autonomy than in option 1a and 1b.	• **Governance** – No current Clinical and governance infrastructure in place so this would need to be established to deliver the service effectively. • **Expertise** – While there is currently some staff within DCC who have experience of leading and working within the Public Health Nursing Service DCC will need to secure clinical leadership and operational expertise. • **HR** – Recruitment and retention of public health workforce, particularly for new roles would need careful consideration. If new staff are offered appointment on DCC terms and conditions and not offered NHS Pensions there is a potential risk this may impact on the ability to recruit new staff, particularly if neighbouring PHNS providers offer NHS terms and conditions (including NHS Pensions). • **Stakeholder concerns -** the consultation undertaken identified this option as the least most popular option for those that responded. • **Financial Risk** – Full risks would be borne by DCC without any level of risk-share with independent providers. Traceability of the use of the Public Health Grant may become complex.

	• **Costs** – there will be additional immediate costs relating to the set up. Initial calculations to scope bringing PHN services in-house have demonstrated that services could be delivered within budget but this will be dependent upon on the final TUPE information supplied. • **Social Value** - There is limited social value created: there is no direct impact on the local economy and no opportunity for smaller or third sector organisations to play a part in service delivery.
Opportunities	**Threats**
• **Re-design** - There is an opportunity for re-designing services and integrating services with other DCC services.	• **Legal challenge** – There is a potential risk of a legal challenge if any of the current ICS services are not procured within the open market.

Option 2b: DCC direct delivery of the PHNS through a wholly owned Special Purpose Vehicle

Section A: Summary

Description
This option considers an approach of not procuring a PHNS but establishing a Special Purpose Vehicle (SPV), from which the PHNS will operate. The contract for delivery of the PHNS could then be directly placed with the newly formed SPV removing the need for procurement and allowing strategic control of the operations within the SPV as the SPV would be a wholly owned subsidiary of DCC. By placing the activity within the SPV DCC remains in strategic control, whilst benefitting from the clarity of separation day to day of all service delivery from other DCC business. This could be useful for example with regard to: • Limitation of liability if necessary away from other DCC services and may impact on e.g. insurance cover • Use of external IT systems • Clarity of charges for all DCC systems that the SPV would need (or sourcing its own business support activity if that was more cost effective), • Branding for the separate company to clearly identify Health Visitors as a Health Service • Upholding any regulatory requirements (such as CQC registration) for only this organisation • The SPV would be able to pursue wider sources of funding, if appropriate not available to a Council • Staff transferring into SPV would be on either NHS terms and conditions, or the terms and conditions that have applied as recruited by VCL. If additional staff are appointed to the SPV it is likely that they will need to be on the basis of equal pay between SPV employees and DCC employees. However, this does depend on the exact set up of the SPV. The ability to offer different terms and conditions for new staff will be advantageous if the service was to be out-sourced in the future as it means the staffing arrangements do not impede this and DCC is not left with long term contingent liabilities underwriting expensive pension/redundancy costs; • Will ensure direct and appropriate use of Public Health Grant monies, in accordance with the requirements of the Grant determination. The actual constitution of the SPV could be considered to ensure maximum benefit to both the immediate and medium-term goals of DCC. Options include establishing a for profit organisation, (either distributable or not) or a not for profit organisation, which could be limited by guarantee or shares, or could be a Community Interest Company. Corporate Taxation, VAT, audit, reporting and other financial compliance issues would need to be considered. This option would rely on a 'lift and shift' of the majority of the existing workforce (c170-200wte) into the SPV. This option would put DCC in direct control at a strategic level of the PHNS and provide an opportunity to align the service with other children and family services DCC provides/commissions. Equally, from an external standpoint the separation of the activity within a stand-alone organisation could facilitate greater alignment with wider children's services by enabling swifter responses and direct action.

Section B: Key Features

Structure
It would be up to DCC to determine the best structure for delivery of the service. The SPV would have its own Board with the day to day control of the company falling to the directors who would report directly to the Authority. Regulatory issues in relation to clinical governance and CQC registration would need to be addressed for the SPV. However, this option would mean that the regulatory requirements would be restricted to the SPV only and not apply to the whole of DCC.
HR features
TUPE would apply to all service transfers. Staff transferring into SPV would be on either NHS terms and conditions, or the terms and conditions that have applied as recruited by VCL. If additional staff are appointed to the SPV it is likely that they will need to be on the basis of equal pay between SPV employees and DCC employees. However, this does depend on the exact set up of the SPV.
Legal features
There would not appear to be any legal obstructions to this option. Legal advice (internal and external) would be needed in relation to the setting up of the SPV.
Financial features
The contract for the delivery of the PHNS and any other children's services would be placed with the SPV. The contract would be specific about the budget, The SPV would have a different taxation regime from that of DCC, in relation to corporation tax and VAT. Corporation tax may be payable on any "profits" created by the SPV, and the transfer pricing for any services bought by the SPV from DCC would need to be given due consideration to ensure the transfer is at cost and does not give rise to taxation or state aid issues for the SPV. There would be additional costs incurred in both the set-up of the SPV and the on-going financial compliance elements (tax, audit, reporting to companies house etc.)
Procurement features
No procurement process would be required.
Timescale and achievability
All timings are within the power of DCC to achieve. Additional resource from programme management, HR, Finance, Legal and other business support services as well as external expertise will be required in preparation for and at the time of transition. With the additional resources secured the deadline of April 2019 is considered achievable.
Other Considerations

This option provides the opportunity for the PHNS service to align closely with other children's services delivered by DCC with the minimum disruption through the strategic control of the SPV.

Section C: Ability to Meet Objectives

Objectives	Ability To Meet Objectives	Score (1-10)
To ensure Devon residents have open access to high quality Public Health Nursing Services: • services are compliant with national clinically recognised standards • there are clear mechanisms for quality assurance • governance processes are robust/fit for purpose.	DCC currently has no relevant clinical governance structures or processes in place. This will need to be developed by the SPV for use within the PHNS only. Additional compliance with CQC and e.g. insurances would be needed. With the additional resources secured this is all achievable within the timescale in order for Devon to have a PHNS which delivers this objective.	8
To ensure Devon has an effective Healthy Child Programme and an integrated system, in which all service providers, commissioners and stakeholders work collaboratively to ensure services are evidence based and promote positive child health for its population and improve children and young people's health outcomes.	The PHNS element of HCP would be fully supported through this option due to the direct lines of accountability. There would be a reduced need for a commissioner/provider relationship due to the internal lines of accountability. However, other NHS-based elements of the Healthy Child Programme may be more difficult to engage if PHNS clinical governance is perceived to be weaker.	7
To ensure that the process for the re-provision of the PHNS does not adversely affect service quality and access.	The transition would need to be very well planned, managed and implemented to ensure that there was no disruption. This option is considered achievable within the timescales. Considerable change would result, and substantial reassurance of clinical staff would need to be provided to achieve a smooth transfer. DCC would need to take great care to minimise loss of staff morale and confidence as the professional framework supporting nursing staff would need to be satisfactorily replaced. The separation of the PHNS from other core DCC services would help to reassure nursing staff and reduce some of the workforce anxiety expressed in the previous PHNS consultation undertaken in January 2017.	6
To ensure the PHNS is capable of delivering the outcomes detailed within the service specification within the available DCC Public Health Grant allocation.	This option would mean that DCC would strategically control the service, via the company. This option will provide assurance of the direct and appropriate use of DCC Public Health Grant allocation in accordance with the requirements of the Grant determination. There may be options for greater linkages with co-dependent services within DCC e.g. information sharing could become easier.	8

	The current financial plans indicate that in the medium term the service could be delivered within the available budget. However, it is expected that during the mobilisation phase of the service additional resources will be required to ensure DCC has the necessary capacity and capability to ensure a smooth transition.	
To ensure that the service delivery model aligns with the strategic vision for the Local Authority (Best Start in Life).	This option provides a good opportunity to align DCC's social and health care responsibilities for children, young people and families.	9
To ensure that the PHNS is agile and responsive so it is capable of flexing and adapting to changing future needs. This includes the ability to react quickly and adopt new, more efficient ways of working effectively in a timely manner such that best value for money is achieved on an ongoing basis, whilst continuing to drive up quality.	The service could be more responsive as there would be a more direct commissioner/provider relationship should change be needed. But without market competition, best value for money may not be achieved and innovation/input direct from the market may also not be identified at such an early stage. Delivery through a dedicated SPV would allow DCC the significant levels of flexibility with regard to making changes relatively quickly and easily in relation to budget, service demands and changes e.g. in technology that could achieve efficiencies for the service.	9
	TOTAL	47

Section D SWOT Analysis

Strengths	Weaknesses
• **Clarity of management** – the SPV would have a Board which was directly accountable into DCC chief officers • **Increased opportunity to align PHNS with DCC children services**. • **Financial risk to DCC –** The SPV would have a contract with a specification to deliver against and an agreed contract price to support that activity. Any further support needed from DCC would need to be "bought" at cost thus ensuring value for money and accountability. Additionally, the requirements of the Public Health Grant (direct traceability) would be met. • **Branding –** This allows the ability to retain a strong PHNS brand • **Autonomy** – this option allows for more autonomy than an in-house option, and absolute focus on the PHNS and any other contracted activity. •	• **Set-up costs –** there will be additional immediate costs relating to set up and there will be costs associated with the reporting and regulation of the organisation (relating to e.g. tax compliance, VAT, audit and financial regulation) on an ongoing basis. • DCC would still need to contract manage the arrangement, so no savings would be released at a corporate level. • **Governance** – Clinical governance mechanisms would need to be established by DCC as part of the SPV. • **Workforce –** There is likely to be an impact on the staff, including individuals potentially leaving the service. • **Social Value** – There is no opportunity for out of area profit based organisations to be involved in the delivery of these services, thus retaining social value. • **HR** - the terms and conditions for staff are likely to be compliant with those of DCC, which may impact on any external tender in the future.
Opportunities	**Threats**
• **Re-design** - There is an opportunity for re-designing services and integrating services with other DCC services. • **Development** - The SPV could provide the vehicle to deliver other DCC services and could even be developed to deliver services on behalf of other organisations (public sector) if this was a desirable strategic output for DCC.	• **Legal challenge** – There is a potential risk of a legal challenge if any of the current ICS services are not procured within the open market.

4.0 Option appraisal summary

4.1 The options appraisal identified that, except for option 1b, all the service delivery options are all achievable within the timeframe. All options were assessed as having a high degree of confidence that the service would be deliverable within budget. The summary table provides an overview of the scoring assessed against the strategic objectives. The table demonstrates that while each option has strengths and weaknesses the overall scoring for the options, excluding option 1b, are comparable. Actions would be required to mitigate as much as possible the weaknesses identified in all the options

Summary of options appraisal

Strategic Objective	1a	1b	2a	2b	Comments
1	10	9	8	8	Option 1a would be the lowest risk option in achieving this objective as the tender process ensures that the award of contract is only possible to a provider who demonstrates full compliance with these quality requirements. The scores for option 2a & 2b are predicated on DCC putting in place the necessary clinical leadership, processes and governance arrangements to uphold quality assurance. As these will have to be developed in full a score less than 1a & 1b has been awarded.
2	8	8	7	7	The current service is provided within an integrated children's service. Ensuring a more joined up health and care system for children, young people and families was a prominent theme identified within the consultation, as was the need to ensure the PHNS is not diluted at the expense of the delivery of the universal health child programme. Assurance of the continued focus on the delivery of the Healthy Child Programme would elevate the scores for option 2a & 2b to equal option 1a & 1b.
3	8	1	6	6	Option 1b has scored 1 as this has been identified as not achievable within the required timescales and therefore would have a significant impact on the service quality and access. Key to achieving this objective is the capability to retain and continue to recruit a high quality PHN workforce. The consultation expressed some concern in relation to terms and conditions of employment and particularly access to NHS Pensions. If early assurance can be given to the workforce in relation to retaining comparable terms and conditions, including access to NHS Pensions, the scores for option 2a & 2b would be increased.
4	9	8	8	8	Option 1a would be a block contract so expenditure would be almost certainty contained within the allocated public health grant although this would depend on a successful procurement and award of contract within the financial envelope. The other options do present slightly less certainty in relation to delivery within budget as these will require the establishment of new services.

5	7	8	9	9	Options 2a & 2b will provide the greatest opportunity to ensure the services are aligned to the local authority vision as the local authority will be in direct control of service delivery. The inclusion of a clear strategic vision within the service specification and the ability to articulate this within market warming events would increase confidence in the ability to achieve this through options 1a & 1b which therefore could increase the score of these options.
6	7	8	10	9	Option 2a provides the best opportunity to provide an agile and responsive service offer as DCC will have direct control of the service. While the principles of this objective can be included within option 1a there would inevitably be contractual processes to be undertaken to achieve this which may impact on the capability to react to changing future needs within a timely manner.
TOTAL	**49**	**42**	**48**	**47**	

APPENDIX A

Indicative Procurement Time Table PHNS Contract

ITT		
TASK	**DEADLINE or DATE**	**Time Allowed**
PNF, Options appraisal / business case / impact assessment		
Market Testing and Engagement		
Service User consultation (this could add up to 8 weeks to the process)		
Develop Specification		
Forming Tender Documents and evaluation questions		
DCC Cabinet sign-Off		
Tender sign Off of T&C's, ITT and Evaluation Questions.		
Ojeu notice	16/04/18	(need to allow 5 days for OJEU notice prior to launch)
Launch Tender	23/04/18	6 weeks as complex and new to the market
Tender Closing date	01/06/18	
Evaluation Process (Compliance, Selection, Quality evaluation, Moderation and financials)	04/06/2018 – 01/08/18	2 Months
Preparation of evaluation and debrief reports and Award Approval report. Due Diligence checks.	01/08/18 - 31/08/18	1 Month (due to Summer holidays)
DCC Cabinet	tbc	Plus 5 days call in
Stand still period begins - ends	18/09/18 – 28/09/18	10 days
Implementation	01/10/18 - 01/04/2019	6 months
Contract start date	**01/04/2019**	

	Procurement
	Commissioning
	All

APPENDIX B

Indicative Procurement Time Table PHNS Contract Competitive Process with Negotiation

Task	Date
Consultation	TBA
Specification design	TBA
ITT design	26th February 2018
Publish Advert	**29th March 2018**
Issue ISIT Documents to Tenderers	**29th March 2018**
Bidder Event	**5th April 2018**
Last Date for Tenderers to submit ISIT Questions	**1st May 2018**
Last Date for the Authorities to Answer ISIT Questions	**3rd May 2018**
Deadline for Initial Tender submission	**10th May 2018**
Authorities evaluate and moderate Initial Tenders	**17th May 2018 to 14th June 2018**
Notification of results of ISIT stage. Unsuccessful Tenderers notified of the reasons	**21st June 2018**
Negotiation with selected Tenderers	**3rd July 2018**
Negotiation closed. Issue ISFT Documents	**13th September 2018**
Last Date for Tenderers to submit ISFT Questions	**4th September 2018**
Last Date for the Authorities to Answer ISFT Questions	**1st October 2018**
Deadline for Final Tender submission	**8th October**
Evaluation of Final Tenders	**11th October to 25th October 2018**
Moderation	**29th October 2018 to 2nd November 2018**
Preferred Bidder identified/Contract Award report and sign off	**8th November 2018 to 14th November 2018**
Confirm availability of team with Preferred Bidder	**15th November 2018**
Standstill notices issued	**14th November 2018**
Award Contract	**26th November 2018**
Inaugural Meeting	**28th November 2018**
Commence Mobilisation	**29th November 2018**
Service start	**1 April 2019**