

Accountable Care System Inquiry

Recommendations with Supporting Narrative

Recommendations

Recommendations to Cabinet that

1. Developing an integrated strategic commissioning function for health and social care should be endorsed as an enabler to aid the delivery of a joined-up health and care system and that option six should be agreed as the direction of travel.

2. As this is a new and untested way of working, the recommended approach is that the transition period (described as shadow working) should be developmental and incremental, testing, reviewing and refining the emerging model. The outline business case should provide clarity on the following:

- i. Details of the proposed form of a new commissioning board;
- ii. How democratic accountability and clinical leadership will be retained be explicit;
- iii. Clarification of the separation between strategic and tactical commissioning;
- iv. How the parameters set by Cabinet are met through this proposal;
- v. Details of the proposed gateway criteria for each phase, metrics, assessment / assurance process and governance for approval process within the council;
- vi. Mechanisms for ensuring trust and confidence between partners are maintained;
- vii. The scope of strategic commissioning, including children and young people services, specialised commissioning and primary care.

3. The inquiry panel also received evidence that demonstrated the need for improved communication regarding the wider Accountable Care System proposals and the development of an Integrated Strategic Commissioning function and recommend the following:

- i. Proactive communication to the public using clear and consistent messaging explaining the Accountable Care System and the Integrated Strategic Commissioning function;
- ii. The language used is changed to reduce confusion, i.e. that the term Accountable Care Systems is not used as this is associated with

Accountable Care Organisations and that the term 'vehicle' in describing the joint board / committee, is not used as this could be interpreted as a new organisation.

Recommendations to Committee

4. An inquiry process be held to consider developing proposals for provider change

5. The Accountable Care System Inquiry (Integrated Strategic Commissioning) Panel undertake a review process as the business case is developed

6. The Health and Adult Social Care Overview and Scrutiny Committee receive timely updates on the performance and progression of the developing plan in order to maintain effective challenge and scrutiny.

Supporting Narrative

1. Context

1.1 At the meeting of the Health and Adult Social Care Overview and Scrutiny Committee held in November 2017, agreement was reached to conduct an inquiry process in respect of the development of a shadow Accountable Care System for integrated strategic commissioning. Draft Terms of Reference were tabled at the meeting. The determination of the Terms of Reference for the inquiry process was delegated to the Strategic Director for Children, Families and Adults in consultation with the Statutory Scrutiny Officer and the Chairman and Vice-Chairman of the Committee. These were agreed on the 12 December 2017.

1.2 It was agreed that six Committee Members, Councillors Biscoe, Jenkin, C Martin, McHugh, Nicholas and Virr (Lead Member), be urgently convened as the Inquiry Panel with membership being agreed at the meeting. At the first formal meeting of the Inquiry on the 19 December 2017, Councillor Virr was elected Chairman of the Inquiry Panel.

1.3 The Panel identified witnesses they wished to receive evidence from during the inquiry. This was in the context that whilst the information that would be provided would enable them to formulate a view, they had already received information as part of the Health and Adult Social Care Overview and Scrutiny Committee which provided a base of knowledge. This included the findings of the Care Quality Commission 'Quality of Care in a Place' review. The review concluded that services need to make urgent and significant change to improve and work better together to ensure that people get the services they need as they move through the system.

1.4 Unlike in some other inquiry reviews undertaken by overview and scrutiny committees, the process was primarily focussed on witness evidence developing

knowledge and understanding in order to meet the Terms of Reference. Therefore the accumulation of evidence over the course of the inquiry informed the recommendations.

1.5 Over the four days of the inquiry the Panel received evidence from a wide range of stakeholders. This included:

- Kathy Byrne – Chief Executive Royal Cornwall Hospital Trust (presenting on behalf of system partners)
- Amanda Fisk – Director of Assurance and Delivery, NHS England (South West)
- Judith Dean – Systems Transformation Director
- Kate Kennally – Chief Executive, Cornwall Council
- Steven Pleasant – Chief Executive at Tameside Metropolitan Borough Council, the Head of the Paid Service and Interim Accountable Officer for Tameside and Glossop CCG
- Caroline Court – Director of Public Health, Cornwall Council
- Helen Childs – Chief Operating Officer, NHS Kernow
- Stuart Roden (Unite), Jonathan Lord (BMA) and Neal Harrington (Unison) - Workforce Representatives
- Jonathan Price – Adult Social Care, Cornwall Council
- Trevor Doughty – Director of Children, Families and Adults, Cornwall Council
- Ned Naylor – Deputy Director, Systems Transformation Group, - NHS England (National)
- Amanda Stratford and Jody Wilson – Healthwatch Cornwall

1.6 Following an opportunity for public submissions, as advertised on the Cornwall Council website and in press releases, a number were received totalling 60 pages. These were acknowledged by the Panel and were taken into account when reaching their recommendations.

2. Areas of findings

2.1 The Panel were informed on the 19 December 2017 in the presentation by Kathy Byrne that the Integrated Strategic Commissioning function covered the development of the following:-

- Develop and implement an integrated strategic commissioning function
- Develop a place based strategy and outcomes framework
- Develop links with neighbouring strategic commissioners
- Oversee procurement process for new service models
- Accountability for securing quality, delivering value, setting medium term financial framework and holding providers to account for operating within financial envelope

2.2 In the presentation by Kate Kennally on the 10 January 2018, the Panel were informed of six options which could be developed to meet the proposed function, along with the relevant assessment criteria. On the 15 January 2018, Helen Childs and Caroline Court provided Members with information relating to the scoring of the options that had been undertaken by an officer group formed from across the four organisations involved. Jonathan Price confirmed the view of Cornwall Council officers at the meeting held on the 31 January 2018. The officer analysis recommended that Option Six be developed. As the amalgamation of evidence emerged, the Panel agreed with this recommendation.

Option Six

2.3 On balance of the evidence received, the Panel felt that Option Six provided the system with ability to develop a body which could have the strength to hold the whole system to account, support effective governance and provide a united voice. It was considered that this option showed ambition within the system to improve strategic commissioning. It provided the ability for the sovereignty of organisations to remain the same but enable joint decision making through a formal joint structure with democratic and clinical involvement. This option could progress collaborative commissioning and reduce competition in the system.

2.4 The Panel accepted that this option was not without concern, as identified in the recommendations; but felt that they could support the direction of travel and were confident that as a long term goal, the integrated strategic commissioning function as a collaboration of the four organisations would be beneficial. There would need to be an evolutionary approach in developing this option, this view was reaffirmed by the evidence provided by Steven Pleasant and his experiences in Greater Manchester. If a gateway test is not met by a target date, it should be the timetable that is flexible, not the test standard.

2.5 As this is a new and untested way of working, the recommended approach is that the transition period (described as shadow working) should be developmental and incremental, testing, reviewing and refining the emerging model.

2.6 This option should strive to create a structure of robust commissioning. In the evidence provided by Ned Naylor he expressed the view that an integrated strategic commissioning function should be able to produce a cohesive strategic view of where the system needs to deploy resources, can remove perverse incentives and create an environment to think collaboratively for the best outcome for the population.

2.7 The Panel did consider all the options that officers had presented, below are the findings relating to each of these.

Option One

2.8 The Panel felt that this option should be discounted. In none of the evidence received did the panel hear that 'doing nothing' would be a plausible way forward. The System Review undertaken by the Care Quality Commission in autumn 2017 showed that there had to be changes in the system. Representatives from the workforce reinforced the view that Option One was not something that could be considered.

Option Two

2.9 The Panel considered this option carefully. From evidence received it felt this could have been a possible option to progress. After reviewing the options appraisal by officers and considering the context in which the system is operating, the Panel recognised that work had been done recently in advancing the use of Section 75 agreements locally. However, they considered that the option is limited and felt it had inherent problems in that it was not sufficiently strategic or patient outcome focussed. The likelihood for confusion and commissioning siloes remained with multiple teams and organisations, and a continuing risk of further cost shunting likely as funding pressures increase.

2.10 The Panel were aware from evidence provided by both Kate Kennally and Helen Childs that the ability to use the Section 75 agreements had been available since the National Health Service Act 2006 and could have been enacted since 1996 through previous agreements. However, in Cornwall they had not been used effectively for strategic commissioning in this time. It was therefore felt that choosing this option would not produce a significant long term positive change in direction for the system. This option retains democratic control of social care and clinical control of healthcare but does not provide truly integrated leadership.

Option Three

2.11 The Panel did not feel that there was sufficient evidence to support this option. There were significant concerns due to the legal directions placed on NHS Kernow and ongoing financial control. The panel was explicitly told that input from elected members would only be advisory and that the Clinical Commissioning Group board would have all voting rights. The panel felt that this was an unacceptable loss of democratic control. Additionally, there would be the loss of some VAT efficiencies.

Option Four

2.12 The Panel did not feel that there was sufficient evidence to support this option. Concerns were expressed that whilst there was an agreement that historic debt would not transfer, there was a risk regarding future shortfalls in funding. Public submissions and evidence from Healthwatch Cornwall identified that there were perceptions that Cornwall Council would not be a suitable

organisation to solely commission health services. Another consideration was that of the impact on the Council of the Isles of Scilly, in this option they would have to delegate to another local authority and whilst not explored in detail it was believed that this would be of concern. In a reversal of the situation of democratic oversight in Option Three, due to the governance of the authority, clinical leadership could be lost. It was recognised that this option would simplify the commissioning and that Cornwall Council being the lead organisation would lead to some financial advantages, with some additional goods/services becoming VAT exempt but this was not considered to be a strong enough reason to recommend that the option be pursued.

Option Five

2.13 It was not considered that splitting the strategic commissioning of children and adults would be helpful in achieving a coherent and collaborative system. Concerns highlighted in the consideration of Options Three and Option Four applied to this option.

2.14 The Panel were apprehensive that this option would limit commissioning and visions for a population based approach. Concerns were expressed that this Option contained inherent risks detaching children and adults services and could impede the transition between children and adults services.

3. Terms of Reference

3.1 The Panel considered that they had been able to achieve the first two parts of their Terms of Reference via the wealth of evidence they received and were able to use that information to inform their recommendations.

3.2 They understood the rationale behind the establishment of Accountable Care System, Integrated Strategic Commissioning, for Cornwall and the Isles of Scilly. This was demonstrated in a number of the presentations received including that by Kathy Byrne, from the representation made by workforce representatives and by Kate Kennally.

3.3 They believed that they had been able to consider the options put forward for integrated strategic commissioning as part of a Cornwall and Isles of Scilly Accountable Care System and question officers on the assessment criteria and the officer group outcomes, including the options discounted. This enabled them to make recommendation on which option is more likely to achieve the desired outcome.

3.4 It was understood that the route map to achieve the preferred option was still developing but that there was an agreement between partners on how to proceed in the initial stages to develop a business case.

3.5 However, they believed that there was not enough information on which to ascertain how democratic control and clinically led commissioning could be

retained beyond the initial observations. In light of this, they recommend that as the business plan develops and clarity of the proposed form of a new commissioning board become apparent, that details regarding how democratic accountability and clinical leadership will be retained should be explicit.

4. Further Observations

Gateways and Assurance

4.1 The Panel were provided with information on gateways in the presentation by Trevor Doughty and Jonathon Price. This provided useful information on what the gateway process would be. However, the details of the gateways needed to be defined. Each organisation needed to be assured of what checks and balances would be in place in order to instil confidence in moving forward and in reviewing the approach.

4.2 Further details of the proposed gateway criteria for each phase, metrics, assessment / assurance process and governance for approval process within the council needed to be provided. There had to be the ability for the development to be scrutinised and measured in order to progress.

4.3 The process should consider the learning of other areas, such as Greater Manchester and Surrey Heartlands as contributory factors to the gateway criteria.

4.4 Members of the Panel felt that there could be metrics already used which might aid the development of criteria, and be common to all partners, for example using elements of the Care Quality Commission key lines of enquiries.

4.5 The gateway and assurance process should ensure that the function is developing in order to provide strength to commissioning for patient outcomes and deliver the best care for people's needs.

Timescales

4.6 The Panel observed that there was apprehension over the timescales being proposed for the development of the function. It was considered that whilst there should be a pace of change set, this should not be at the expense of ensuring all aspects of the business case are successfully tested. There was no required timescale set nationally and the system in Cornwall needed to undertake the process at an appropriate pace for itself.

Clarification of Scope

4.7 There was confusion regarding the extent of the scope of the function, this was demonstrated in the challenge by the workforce representatives relating to the number of employees that might be impacted of any change. There had been no clarification of the differential between strategic and tactical commissioning.

4.8 The evidence provided by Trevor Doughty and Ned Naylor prompted questions over the scope of the integrated strategic commissioning relating to particular elements of commissioning. The business case should clarify the scope of strategic commissioning, including children and young people services, specialised commissioning and primary care.

Public Concern and Language

4.9 The submissions from the public, from Healthwatch Cornwall and from workforce representatives demonstrated the significant amount of public concern regarding the development of an accountable care system in Cornwall. Many of the submissions related to provider form which was beyond the remit of the inquiry. However the Panel recognised that there was the development of an accountable care partnership and sufficient scrutiny of that process might help to allay fears.

4.10 Some information on social media about the process and scope of an accountable care system had caused confusion. The Panel observed that there had not been a consistent proactive response from the system to the concerns of the public. The lack of messaging further eroded trust in organisations and added to public fears. It was considered that there needed to be an open conversation with the public and that myths were dispelled. The system should not be afraid to share its views and engage with those who have concerns. The ability to communicate effectively as one voice could help to assure the public that the system could work together to produce one plan and vision.

4.11 The language used was of concern to Panel and it recommended that this changed to reduce confusion, for example, that the term Accountable Care Systems is not used as this is associated with Accountable Care Organisations and that the term 'vehicle' in describing the joint board / committee, is not used as this could be interpreted as a new organisation. The perception of the term 'shadow' also caused confusion as there appeared to different interpretation of the meaning. The Panel suggested that a more appropriate description of the developmental phase be found that all partners could be comfortable with.

4.12 In general, terms seemed to be used interchangeably, with little clarity and this did not help in addressing public anxieties or producing easy to understand information.

4.13 Whilst not directly within the remit of the inquiry public submissions, the evidence provided by workforce representatives highlighted the concerns relating to development of the workforce across the system and with funding.

4.14 It is suggested that the development of any integrated strategic commissioning function should ensure that workforce development is a constituent part of commissioning across the sector.

4.15 Funding whilst a contentious issue and beyond the remit of the inquiry was raised as a matter of concern. The Panel noted that whilst funding was a driver for change, it was not the only driver, there appeared to be a desire to ensure strengthened strategic commissioning would drive improvement and increase accountability in the system. Witnesses had acknowledged that additional funding alone would be unable to resolve the weaknesses in the system highlighted by the Care Quality Commission.

Recent Concerns Raised in Government

4.16 The view had been expressed by the public and by Members observing the inquiry that action undertaken by Jeremy Hunt, Secretary of State for Health and Social Care, in relation to accountable care organisations should impact on the development of the accountable care system in Cornwall. This was clarified by Ned Naylor in his evidence to the Panel. He explained that the action taken was related purely to the contracting within an accountable care organisation and not to the development of integrated strategic commissioning functions as an accountable care system. Furthermore, he added that the development of an integrated strategic commissioning function would not have to lead to the development of an accountable care organisation, and this was not required by NHS England.

Health and Wellbeing Board

4.17 The Health and Wellbeing Board were identified as a potential board in order to progress Option Six. It was felt that the governance and assurance related to this to be fully considered and explored. It would require constitutional change within the authority, and there would need to be consideration of the statutory duty of the Council of the Isles of Scilly to have its own Health and Wellbeing Board. It was suggested that a new joint integrated commissioning board be established rather than the Health and Wellbeing Board.

The Panel would like to thank those who provided evidence to the inquiry and those who attended the sessions.