CORNWALL COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW
AND SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Adult Social Care Overview and
Scrutiny Committee held in the Council Chamber, County Hall, Truro, TR1
3AY on Monday 5 February 2018 commencing at 10.00 am.

Present:-

Councillors: A Toms (Chairman)
C Martin (Vice-Chairman)
Biscoe, Chopak, Dwelly, Ellenbroek, Hawkins, Jenkin,
K McHugh, Nicholas, Pollard, Saunders, J Thomas, Virr and
P Williams.

Also in attendance:-

Councillors: Eathorne-Gibbons, Egerton, Ekinsmyth,
Heyward, McKenna, Olivier and Rotchell.

DECLARATIONS OF INTEREST
(Agenda No. 2)

HASC/OSC46 There were no declarations of interest.

PUBLIC QUESTIONS
(Agenda No. 3)

HASC/OSC47 Three questions were received from the public.

Public Question No. 1

Dr A Davis of Gorran (not present his question being read by the
Chairman), asked if an Accountable Care Organisation was formed in
Cornwall, whether it would inherit any PFI (Private Finance Initiative)
repayment commitments from the health community in the county and if
that was the case what the scale of these debts would be, and how they
would be managed.

In response, he was advised that the NHS had three PFI properties in the
county at Liskeard, Bodmin, and Camborne-Redruth. The agreements for
Bodmin Hospital and Longreach at Camborne-Redruth were held by
Cornwall Partnership Foundation Trust, and the extent of the financial
obligations was set out in their accounts each year. The agreement for
Liskeard Hospital was held by NHS Property Services (a national company
wholly owned by the Department of Health and Social Care) and current
information on the financial liabilities for this scheme was not held.
Future arrangements were yet to be agreed but would depend on any
statutory transfer arrangements, work on the estates options for Cornwall
Devolution deal and/or local negotiations. As modern, maintained
elements of the local estate, making sure the local NHS got use and value
out of the properties would be an important factor in all future plans. Any reassignment of a PFI contract would require funder approval.

**Question No. 2**

Mr F Richens of Bude stated that he was concerned that the papers on this subject were tabled at the meeting where it was to be discussed. This was too late. He considered that the public expected its elected representatives to be fully briefed and, if they deemed it to be necessary, to have time to talk with their constituents, before they took major decisions. In addition, the public deserved to have sight of important, non-confidential papers well in advance of meetings. He therefore questioned why this state of affairs had come about and what the executive would do to ensure that it never happened again.

In response he was advised that over a period of four days, the inquiry had reviewed a substantial amount of documentation and listened to a wide range of witnesses. The inquiry had concluded last Wednesday. Members of the public had been free to attend each of the inquiry sessions and had also had an opportunity to make written submissions. Today’s extraordinary Health and Adult Social Care Overview and Scrutiny Committee provided everyone, Members and the public alike, with an opportunity to review the findings and recommendations from that process. The timings for the process had changed. However, this was not the end of the process as the decision whether to proceed with the proposed option would not be made by the Cabinet until 28 March.

As members of the public may be aware, it had initially been planned that the matter would be discussed by Cabinet on 7 March, which truncated the timescales. Although this had now changed, continuing in the previously agreed timescales allowed for the work of the Panel to be fully understood by Cabinet. It also provided time for the public to speak to their local Member and make their views known before that final decision was taken. Partners in the system were also considering the options, for example the Clinical Commissioning Group Governing Body was meeting tomorrow.

In his supplementary question, Mr Richens referred to the hard work of the Democratic and Governance Officer in producing the report. He remained concerned however that there appeared to be little evidence to support the direction of travel and the confidence of the staff needed to be taken into account. He therefore asked whether more time could be found to communicate with the public before a decision was taken.

In response, reference was made to the findings of the inquiry which would be discussed later in the meeting. He was also advised that how services were organised in localities was important to Shaping Our Future. This work was ongoing and was about finding out what was important to Cornwall in terms of its health and care services. Opportunities to engage in the process were on its website. This was not what today’s meeting
was about as its focus was on strategic commissioning i.e. how the four statutory partners (Cornwall Council, the Council of the Isles of Scilly, NHS England and NHS Kernow Clinical Commissioning Group) worked to spend the available resource for health, care and wellbeing in Cornwall.

Question No. 3

Ms J Bassett of Bodmin (not present, her question being read by the Chairman), stated that, at the third enquiry day, presentation was made as to six options that had been considered and scoring summaries provided. She stated that, clearly, a vital consideration in assessing any of the options was the effect it was going to have on employment of staff. It was understandable Option 1, derisorily termed as do nothing but effectively a no major change option, had no TUPE implication. The significant effect of TUPE was highlighted in the presentation and the option scoring in respect of options 3, 4 and 5. Option 2 was scored as one that required no significant changes to current structures. It was also scored that it was one which was more suited to commissioning of specific services rather than complete delegated authority for statutory duties. It understandably had no TUPE implications. Option 6, the preferred option, was championed as a new vehicle and that there were financial advantages of working as a single team providing options for greater efficiency. However, no part of the scoring summary involved TUPE implications, meaning these had either not been considered, in which case the process was wholly flawed, or they had been discounted as irrelevant to the scoring summary. She therefore asked what the TUPE implications for Option 6 were, stating that if it was the case that there were TUPE implications, could a full costing be provided of the TUPE consequences of implementing Option 6 and, if it was the case that there were still maintained to be no TUPE implications that there would be no changes to employment of any staff working in the health and social care services in Cornwall.

In response, it was stated that it was important to note that the term 'new vehicle' referred to a joint committee or board and not a new organisation. As such it was not expected that there would be any TUPE implications arising from Option 6 at this stage as the statutory bodies involved in integrating strategic commissioning would continue to exist as employing statutory bodies.

During 2018/19 there would be no changes to staff employment, however as the process was worked through, there could be changes to the working arrangements for staff involved in the commissioning of health, care and wellbeing services – for example, co-locating of teams, change of line management or place of work.
ACCOUNTABLE CARE SYSTEM INQUIRY - INTEGRATED STRATEGIC COMMISSIONING
(Agenda No. 4)

HASC/OSC48 The Business Partner, Commercial Clients, referred to the legal implications set out in the report, advising that there had been some confusion relating to the phraseology being used, namely the Accountable Care Organisation. This was not what the Committee was considering, it was looking at strategic commissioning and how existing organisations worked together to enable this. The Inquiry’s third recommendation dealt with this in detail.

The Chairman of the Committee adjourned the meeting at 10.30 a.m. to enable Members and the public to review the report.

The meeting reconvened at 10.50 a.m.

Councillor Virr, Chairman of the Inquiry Panel, thanked the Democratic and Governance Officer for the huge amount of work that she had done in terms of managing an effective inquiry process, securing appropriate witnesses and producing the final report in a short timescale. He paid tribute to his fellow Inquiry Members and the witnesses that had given evidence. He referred to a number of issues, including:-

i. The status quo was not an option – change was needed;

ii. Option 6 was a sensible approach as it brought together the various budgets and decision makers and left behind organisational boundaries, putting the needs of patients and residents at the heart of strategic commissioning;

iii. The key recommendations, as set out in the report, required the development of a detailed Business Case to bring the commissioners together and to test, refine and report back.

iv. It was clear that there had been a breakdown in communication with the public and the language used which had led to misunderstanding about what was being proposed.

v. The Committee needed to be updated on progress on a regular basis.

The other Members of the Inquiry made comments which included:-

i. Evidence had been heard from a wide range of organisations which confirmed that it was not possible to continue as is.

ii. The name, Accountable Care System was misleading. This was about strategic commissioning of services, not breaking up the NHS.

iii. If the aspiration was for a Cornwall and Isles of Scilly Strategic Commissioning Board which made strategic decisions this could only be a good thing and would address the current fragmentation.

iv. Some witnesses had referenced the delivery – provider form was not in the scope of the inquiry.

v. There was considerable concern about the underfunding of the whole system. An integrated approach to commissioning would
provide a better voice to Government on effective funding. Although not part of the scope of the inquiry, it was something that needed to be addressed and potentially included in the recommendations to Cabinet.

vi. Checks and balances would need to be in place, and gateway points to enable review and to move either forwards or backwards depending on progress.

vii. There was a need to recognise that the proposals related to both Cornwall and the Isles of Scilly.

viii. In due course a separate inquiry could be convened on provider form. In the meantime there was a need for the Committee to review the Outline Business Case.

ix. The proposals did not relate to frontline services as there was an ongoing process, involving doctors and patients that was considering this separately.

x. Option 6 was a balanced approach, involving an equal partnership, rather than one organisation taking over.

xi. The Full Council would ultimately consider the issue later in the year in terms of any constitutional and budgetary issues.

Wider discussion followed, involving all those present and comments included:

i. Concern was reiterated about public engagement and understanding and the need for public consultation. The public needed to understand how it could look in the future.

ii. There was a need to understand the experiences of others who were going through a similar process.

iii. There were numerous unanswered questions including whether, in future, care would be better, debt written off and whether there would be less contracting out to private sector profit making organisations. Reference was made to the fact that many of these issues were addressed in the second recommendation.

iv. It was not the role of the Inquiry Panel to state the format of the Business Case or the nature of the body responsible for delivery.

v. In respect of the financial issues, this had been raised during the Inquiry and Members advised that all four organisations would be responsible for their own financial arrangements. There would not be cross-responsibility and the Council would not be responsible for addressing the NHS debt. The Cabinet had considered a paper in July 2017 which had set out clear parameters for the future and that there would be no pooling of deficits.

vi. There were valid questions for the future about the role of the public/private sectors.

vii. There were opportunities for public engagement through Patient Participation Groups. Healthwatch was also co-opted onto this Committee and provided a means for the public to have a voice.

viii. It was noted that the public in North and East Cornwall would look to North Devon, Derriford and Holsworthy for services. Clarification was provided however that the NHS provided funding in Cornwall for those registered with a Cornish doctor. If a patient was
registered with a doctor in Holsworthy, therefore, the Kernow Clinical Commissioning Group (KCCG) was not funded for them. Assurance was, however, provided that discussions were going on with Devon given that not all services could be provided in Cornwall.

ix. It was confirmed that the governing body of the KCCG was discussing the proposals the next day. The outcome could not be pre-empted as it was a learning process for all involved. No other areas had done this and it was an iterative process. Staff needed to be taken on the journey.

x. The proposals in the Outline Business Case would consider different ways of working. From there a full Business Case would be developed in the autumn. If agreed it would be implemented from 2019-20. The development phase was likely to take a year. The full Business Case should come before the Committee as a draft prior to being considered by the Cabinet.

xi. There was a need for clearer language to promote public engagement and understanding. Engagement was different to formal consultation. The advice stated that the proposals did not meet the test for formal consultation.

xii. The Business Case must be clear in terms of implications for health and wellbeing outcomes, debt and the outsourcing of services. This needed to be taken into account in the recommendations to Cabinet.

xiii. Reference was made to the fact that within the Inquiry Report, paragraph 2.10, 2006 should be replaced with 1999.

Following a short adjournment to consider the Inquiry recommendations and a range of issues raised during the discussion, it was moved by Councillor Pollard, seconded by Councillor Dwelly and

**RESOLVED TO RECOMMEND TO THE CABINET THAT**

1. Developing an integrated strategic commissioning function for health and social care for Cornwall and the Isles of Scilly 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. How 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;

viii. The Business Case sets out clearly the implications in terms of health and wellbeing outcomes, debt and outsourcing of services;

ix. The final Business Case is based on an extensive listening exercise and dialogue which informs the final Business Case.

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.

4. Single integrated commissioning provides a strong voice for lobbying Government for fairer funding.

5. The final Business Case is considered by the Health and Adult Social Care Overview and Scrutiny Committee before Cabinet makes a final decision.

**RESOLVED THAT THE HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**

6. Considers any emerging proposals for provider change.

7. Receives timely updates on the performance and progression of the developing plan in order to maintain effective challenge and scrutiny.

The meeting ended at 1.23 pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].