1. Executive Summary

At the last Health & Wellbeing Board meeting we provided an update on the three programmes of work running in parallel under Shaping our Future

1. Moving to an Accountable Care System (ACS)
2. Development of business case for new integrated model of care
3. Developing a strategic case for Devolution

**Accountable Care System**

Health and social care leaders in Cornwall and the Isles of Scilly (CIOS) have agreed, subject to the relevant approvals, to develop one Accountable Care System (ACS) that is intended to act as an enabler for change, and support the realisation of a transformed model of care.
System for Cornwall and the Isles of Scilly by 2019, comprising an integrated strategic commissioner for health and social care and a network of providers with a single leadership team.

A roadmap to move the system into a shadow working arrangement by April 2018 to test the concept and review / refine the approach prior to formalising changes to organisational form has been set. As part of the shift towards ‘system first’, chief officers have agreed key system roles which are set out in section 3 of this report.

The critical path for the development of the ACS, includes the consideration of a business case for the development of Strategic Commissioning by CCG Governing Body, NHS England and Cornwall Council Cabinet in February and March 2018 respectively, and a business case with service configuration options for the ACP to go to provider boards, cabinet and representative bodies, also in March 2018. In service of the development of the business case for strategic commissioning the Health & Adult Social Care Scrutiny Committee are holding four enquiry days during December and January to consider the options put forward and, for the preferred option, ascertain how democratic control and clinically led commissioning can be retained.

**Development of business case for new integrated model of care**

The model of care programme includes both planning and implementation in parallel. Some elements of the programme can be implemented now for impact in 2018/19. Other parts of the programme, in particular the review of how urgent care needs are met in the community and the future model for re-ablement, rehabilitation and recovery, are subject to the co-production process in train.

Whilst some good progress has been made both planning and implementation has so far been slower than originally expected. There has been a high reliance on stretched operational resources to lead transformation. Operational pressures have naturally taken priority. A revised critical path for development of the model of care is set out in section 3 of this report.

**Devolution**

Ahead of finalising the strategic case for Devolution the Council has sought external and independent challenge on our case from three different parties, all of whom offer unique insight into delivering successful cases to government and how these are best positioned to reflect and respond to government priorities. Feedback from the challenge sessions have helpfully identified areas that require further focus in order to develop a compelling case to central government. It has also been agreed that a number of conditions should be met before we proceed with formally engaging external parties, providing evidence of progress on our improvement journey. These include:

- Strategy for approaching the three year financial strategy for health and social care agreed locally
- Business case for shadow ACS developed for sign off in February 2018 (this will address the recommendations from the external challenge sessions)
- Model of care blueprint developed and agreed
• Warning notice at Royal Cornwall Hospital Trust lifted by the Care Quality Commission

We are committed to develop the strategic case for devolution to enable decisions to be made ahead of public consultation in 2018.

2. Purpose of Report

To advise the Committee of progress within the Shaping our Future programme including progress towards the establishment of for an Accountable Care System, the development of the business case for the future model of community based care and an update on the development of the strategic case for Devolution.

3. Benefits for Customers/Residents

The Shaping Our Future plan is our opportunity to create a locally developed and owned plan shaping how health and wellbeing will be supported in Cornwall and the Isles of Scilly in the future. There is a national requirement by NHS England for a local ‘Sustainability and Transformation Plan’ which we call Shaping our Future.

We intend the Shaping our Future plan to drive a genuine transformation in health and care in Cornwall and the Isles of Scilly. It has to deliver a new way of supporting health and well-being that is clinically viable and financially sustainable, and with a much greater focus on keeping people well and supported in their local communities.

As part of the next phase for Shaping our Future, we are committed to developing the business case for a proposed future model of care that better meets the needs of the people of Cornwall and the Isles of Scilly and in doing so addresses the financial sustainability issues of the current system. In addition we have committed to establish an Accountable Care System (ACS) for Cornwall and the Isles of Scilly to support the delivery of more integrated care.

Developing an Accountable Care System

Through the development of Shaping Our Future, the health and social care leaders in Cornwall and the Isles of Scilly (CIOS) have agreed, subject to the relevant approvals, to develop one Accountable Care System for Cornwall and the Isles of Scilly by 2019, comprising an integrated strategic commissioner for health and social care and a network of providers with a single leadership team.

A roadmap to move the system into a shadow working arrangement by April 2018 to test the concept and review / refine the approach prior to formalising changes to organisational form has been set out as illustrated in the below diagram.
As part of the shift towards 'system first', chief officers have agreed key system roles, as set out in the below table:

<table>
<thead>
<tr>
<th>ACS element</th>
<th>Outline objectives</th>
<th>System CEO Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Commissioning Function</td>
<td>• Develop and implement an integrated strategic commissioning function &lt;br&gt;• Develop a place based strategy and outcomes framework &lt;br&gt;• Develop links with neighbouring strategic commissioners &lt;br&gt;• Oversee procurement process for new service models &lt;br&gt;• Accountability for securing quality, delivering value, setting medium term financial envelope and holding account providers for operating within the agreed financial envelope &lt;br&gt;• Build and maintain neighbouring strategic commissioning relationships</td>
<td>Kate Kennelly</td>
</tr>
<tr>
<td>Accountable Care Partnership</td>
<td>• Oversee prioritisation and implementation of whole system plan proposals to ensure coordinated approach to developing place based delivery of care &lt;br&gt;• Monitor and manage performance and plans – activity, quality and finance &lt;br&gt;• Hold partners to account to manage and mitigate risks and underperformance</td>
<td>Kathy Byrne</td>
</tr>
<tr>
<td>Integrated services organised and delivered in a community setting</td>
<td>• Care model and business model development for community based services – including community hospitals, NHs and UTC</td>
<td>Jackie Pendleton</td>
</tr>
<tr>
<td>Services organised / delivered on a Cornwall-wide (or wider) basis</td>
<td>• Care model and business model development for services organised / delivered on a Cornwall-wide (or wider) basis e.g. specialised / vulnerable services, Derriford links and those requiring specialist facilities, resources or staff &lt;br&gt;• Responsible for engaging critical primary care and mental health clinicians and care professionals in both care model and business model development &lt;br&gt;• Oversight of improved day to day partnership working between organisations and realisation of benefits &lt;br&gt;• Realise benefits of economies of scale through shared corporate services</td>
<td>Phil Coote</td>
</tr>
</tbody>
</table>
The development of an ACP will facilitate the delivery of integrated health and social care services with providers working as a single network, including a range of public, independent and third sector organisations that serve our communities. Six options for the configuration of the ACP are to be considered.

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Do nothing option – provision arrangements remain separate, split between the existing health and care provider organisations with separate decision-making</th>
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<tbody>
<tr>
<td>Option 2</td>
<td>A single ACP leadership team managing and co-ordinating the delivery of services through the existing health and care provider organisations.</td>
</tr>
<tr>
<td>Option 3</td>
<td>A single leadership team managing the delivery of services through a single service delivery unit. Supporting corporate services provided centrally for the ACP</td>
</tr>
<tr>
<td>Option 4</td>
<td>A single leadership team managing the delivery of services through one service delivery unit for services that are organised / delivered on a CIOS wide (or wider) services and one service delivery unit covering health and care services organised and delivered in a community setting. Supporting corporate services provided centrally for the ACP</td>
</tr>
<tr>
<td>Option 5</td>
<td>A single leadership team managing the delivery of services through one service delivery unit for services that are organised / delivered on a CIOS wide (or wider) services and three service delivery units, one for each integrated care area, covering health and care services organised and delivered in a community setting. Supporting corporate services provided centrally for the ACP</td>
</tr>
<tr>
<td>Option 6</td>
<td>A single leadership team managing the delivery of services through one service delivery unit for services that are organised / delivered on a CIOS wide (or wider) services and six service delivery units, one for each integrated care locality, covering health and care services organised and delivered in a community setting. Supporting corporate services provided centrally for the ACP</td>
</tr>
</tbody>
</table>

Each option will be assessed against the following aims:
- Strategic fit with the Shaping our Future priorities / principles
- Value for money
- Sustainability, including workforce
- Quality and Access – equity / consistency
- Ease of implementation / transition

**Integrated Strategic Commissioning Options Appraisal**

Following a similar process, the King’s Fund paper ‘Options for Integrated Commissioning – Beyond Barker’ provides three broad options on how a single commissioning function, with a single integrated budget, could be developed:

- Option 1: Build on existing organisational and policy arrangements
- Option 2: Option 2a: CCG to take responsibility
- Option 2b: LA to take lead responsibility
- Option 3: A new vehicle for strategic commissioning
These broad options have been considered by local commissioners and developed into six more detailed options, to be taken forward into an options appraisal for the development of integrated strategic commissioning arrangements in CiOS.

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Joint commissioning arrangements remain separate, split between the two organisations with separate decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>Greater use of existing funding alignment arrangements, such as Section 75/Better Care Fund</td>
</tr>
<tr>
<td>Option 3</td>
<td>The CCG acts as lead commissioner for all health, social care and public health commissioning</td>
</tr>
<tr>
<td>Option 4</td>
<td>The Local Authority as lead commissioner for all health, social care and public health commissioning</td>
</tr>
<tr>
<td>Option 5</td>
<td>The Local Authority acts as lead commissioner for Children and Young Peoples services. The CCG acts as lead commissioner for Adult Services</td>
</tr>
<tr>
<td>Option 6</td>
<td>Commissioning of health, social care and public health services is undertaken through a new vehicle such as a Joint Health and Care Committee</td>
</tr>
</tbody>
</table>

Each option will be assessed against the following aims:

- achievement of the outcomes set out by the system through the Sustainability and Transformation Plan for Cornwall and the Isles of Scilly
- achievement of straightforward and acceptable governance under current legislation
- achievement of financial advantages for the public purse both through more effective commissioning and cost of delivery of the new commissioning model
- making the most effective use of the workforce skills and experience in CIOS.

In service of the development of the business case for strategic commissioning, the Health & Adult Social Care Scrutiny Committee are holding four enquiry days during December and January to:

1. Understand the rationale behind the establishment of an ACS across the NHSE in England
2. Consider the options put forward for integrated strategic commissioning
3. Within the preferred option, ascertain how democratic control and clinically led commissioning can be retained
Update on the development of new integrated model of care

The model of care programme includes both planning and implementation in parallel. Some elements of the programme can be implemented now for impact in 2018/19. Other parts of the programme, in particular the review of how urgent care needs are met in the community and the future model for re-ablement, rehabilitation and recovery, are subject to the co-production process in train.

Whilst some good progress has been made both planning and implementation has so far been slower than originally expected. There has been a high reliance on stretched operational resources to lead transformation. Operational pressures have naturally taken priority.

A revised critical path for development of the model of care is set out in the high level plan below. Initial elements of the critical path for implementation at pace have also been identified.

Since the last update to the Health & Wellbeing Board the 2nd wave of co-production workshops were completed, a summary of the outputs can be found in section 5 of this report.

To further capture work happening in local areas to develop new ways of working members of the Shaping our Future team are attending GP locality meetings and Community Network Panel meetings.

Wave 3 of co-production is currently in its planning phase, with provisional dates booked for February. Delays in data collection and modelling mean we anticipate a 4th wave of coproduction will be necessary so that the emerging models can be supported with the relevant evidence base.
Following Wave 4 there will be preparation of the business case for public consultation.

Devolution

Over recent weeks the SoF team have been working with the council’s Devolution team to develop the strategic case for Devolution. This is following a series of engagement events with key stakeholder groups over the last four months to build, test and refine our emerging asks to Government. A summary of the draft case can be found on the A3 sheet in the appendix, in the form of a ‘plan on a page’ consisting of 4 key focus areas. For the reasons set out below, this is not yet in its final state of presentation, but in broad terms the existing plan aims to:

1. Deliver a radical upgrade in prevention including using the powers and flexibilities of devolution to implement radical programmes to improve our citizens’ health and wellbeing.
2. Accelerating delivery of new model of care, a flexible workforce and essential infrastructure developments, enabling a more efficient, integrated system, driving up quality and moving faster towards making our health and care system clinically and financially sustainable.
3. Providing an innovation test bed for rural and island based communities.
4. Living within a fair funding settlement and achieving local enhanced accountability by establishing an ACS and the use of a single place based budget, with local controls, to commission and deliver services that are place based and outcomes focused.

The strategic case sets out the role that devolution can now play in stretching our ambitions, combining new devolved freedoms and invest to save funding, with our strong local identity, building on the concept of ‘place’ to develop a comprehensive model of public services reform across health and social care, and delivering key outcomes for local people. This proposal also commits to bring us back to financial balance by 2021 (in line with the objectives of the proposed three year financial plan).

Ahead of finalising the case the Council has helpfully sought external and independent challenge on our case from three different parties, all of whom offer unique insight into delivering successful cases to government and how these are best positioned to reflect and respond to government priorities.

Feedback from the challenge sessions have helpfully identified areas that require further focus in order to develop a compelling case to central government. We need to reframe our case around areas that will be of specific interest to government and build more depth to our proposals. We are committed to develop the strategic case for devolution to enable decisions to be made ahead of public consultation in 2018. This is still very achievable, but timing is absolutely key. At its November Portfolio Board meeting, it was agreed to align the timeframe with the agreed critical pathway for system priorities over the coming weeks. This will facilitate senior staff being able to provide critical contribution to the devolution case in a way which is both efficient and effective at a time of significant strain on the system. System leaders have been agreed to work up the required detail.
It has also been agreed that a number of conditions should be met before we proceed with formally engaging external parties, providing evidence of progress on our improvement journey. These include:

- Strategy for approaching the three year financial strategy for health and social care agreed locally
- Business case for shadow ACS developed for sign off in February 2018 (this will address the recommendations from the external challenge sessions)
- Model of care blueprint developed and agreed
- Warning notice at Royal Cornwall Hospital Trust lifted by the Care Quality Commission

4. Relevant Previous Decisions

Whilst the Outline Business Case submitted to NHS England in October sets out our strategic ambitions no formal decisions have been made in relation to the re-configuration of services or architecture for an Accountable Care System.

5. Consultation and Engagement

Approximately 500 people have attended the two coproduction workshops to date in Cornwall (see table below) and approximately 50 people attended workshops in the Isles of Scilly. Participants represented a wide range of stakeholder groups across health and social care including community nurses; community therapists; social workers; care home managers; mental health practitioners and LD workers; GPs; pharmacists; paramedics, local district nurses, community matrons, social workers, case coordinators, occupational therapists, physiotherapists, community mental practitioners, and health workers who provide routine support to the frail elderly, people with dementia and people with chronic conditions affecting both physical and mental health, local experts by experience be they patients, carers, and local elected councillors that have expert knowledge of the health needs and circumstances affecting specific local communities. In addition, a range of voluntary sector, community network panel and union representatives were invited.

Table 1 Attendance

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Workshop</th>
<th>Wave 1</th>
<th>Wave 2</th>
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<tbody>
<tr>
<td>North</td>
<td>33</td>
<td>24</td>
<td>West</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>West to Mid</td>
<td>49</td>
<td>53</td>
<td>Mid to East</td>
<td>44</td>
<td>38</td>
</tr>
<tr>
<td>Liskeard East</td>
<td>29</td>
<td>41</td>
<td>Mid</td>
<td>46</td>
<td>37</td>
</tr>
</tbody>
</table>

The following is a summary of the wave 2 co-production results

**Prevention and self-care**

a) Our whole population needs to be responsible for preventing ill health and maintaining wellbeing and independence.

b) There need to be local initiatives focused on meeting different needs associated with age, mental health, socio-economic circumstances and postcode.
c) For primary prevention target younger people to encourage healthy habits as early as possible and focus secondary prevention on those currently making the greatest use of services.

d) Explore more holistic solutions to health promotion so answers aren’t always driven by the health sector.

e) Provide more support in people’s homes to encourage them to exercise and maintain good health.

f) Help people stay connected to their communities to avoid the health risks associated with social isolation.

g) Remove access to unhealthy food in hospitals.

h) Professionals should be better role models, promoting health and wellbeing

i) Increase support, for the elderly, within the community.

j) A directory of activities and support that is available in the community is needed. This must be updated and maintained accurately.

k) Need to consider the time it may take for some initiatives to show an effect – financial cycle needs to be longer than one year.

l) Encourage communities to use green spaces to grow healthy food for people on low incomes.

m) Increase access to existing provision e.g. exercise classes.

n) The voluntary sector and patient participation groups are key to supporting prevention work, however “the voluntary sector can be sparse in rural areas/areas with a scattered population” so cannot they can be part of the model everywhere.

o) The importance of early intervention and support for self-management

## Integrated Care in the Community

<table>
<thead>
<tr>
<th>Model of care</th>
<th>Be holistic, include housing, finance, care homes and telehealth in the integrated model and integrate community and urgent care</th>
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<tbody>
<tr>
<td></td>
<td>Have a single point of contact</td>
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<tr>
<td></td>
<td>Roll out the 3 conversations model</td>
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<td></td>
<td>Improve repatriation pathways</td>
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<td></td>
<td>Consider outpatients as part of the model</td>
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<table>
<thead>
<tr>
<th>Integrated teams</th>
<th>Build trust and have co-located multi-disciplinary teams</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Different integrated multi-disciplinary teams are needed for children, people with learning disabilities, people approaching end of life, and for urgent out of hours care</td>
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<td></td>
<td>Commission the third sector to make it sustainable</td>
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</table>

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Identify capacity issues</th>
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<tbody>
<tr>
<td></td>
<td>Reduce variation in health and social care workforce terms and conditions</td>
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</tbody>
</table>
- Expand workforce and blend roles (across all sectors)
- Share budgets
- Have integrated care hubs
- Utilise community hospitals, care homes, and day centres
- Put leg ulcer clinics in social settings

### Urgent and Emergency Community Care

| In designing the model | • Design the model in collaboration with SW Ambulance Service Foundation Trust, non-urgent patient transport, 111 and discharge teams  
| • Minimise travel time and costs for patients, ensure there are appropriate transport links  
| • Minimise waiting times  
| • Increase capacity and access  
| • Consider age differences, age related differences in patient experience |
| Model of care | • Include mental health and social care  
| • Develop a ‘time to think’ service  
| • Include local point of care diagnostics and rehabilitation  
| • Have a single point of access  
| • Review triage  
| • Improve 111  
| • Include a weekend dressing clinic |
| Integrated teams | • Develop trust  
| • Develop urgent multi-disciplinary teams through recruitment, training and use of existing staff  
| • Consider co-location opportunities |
| Sites | • Locations of UTCs on arterial routes is probably a good approach  
| • Have 4 super hubs along the spine of the county  
| • Consider car parking capacity  
| • Falmouth needs a Minor Injury Unit because of its transient population  
| • The CT scanner in the West is used so there should be one in the East, perhaps Bodmin or St Austell  
| • There should be short term observation beds available in the Camborne/Redruth area  
| • Camborne and Redruth Community Hospital and the minor injury unit need to be made more like an urgent care centre to maximise use St Austell needs a centre to stop people going to A&E |
| Benefits | • A treatment centre could relieve pressure in primary as well as secondary care |

### 6. Financial Implications of the proposed course of action/decision

Detailed financial implications cannot take place ahead of the options appraisal stage for either the model of care or ACS design.
7. Legal/Governance Implications of the proposed course of action/decision

All decisions will be made within the required constitutional governance arrangements of all partner organisations.

8. Risk Implications of the proposed course of action/decision

Key risks are reviewed monthly by the SoF Portfolio Board.

9. Comprehensive Impact Assessment Implications

SoF has been informed by a wide range of data, analysis and intelligence to develop our Case for change (Outline Business Case, pages 9-19). This considered population health needs and trends, performance, feedback from local people, finances and supply issues.

- Cornwall’s population is older than average with the greatest population increases expected in the older age groups.
- Birth rates are increasing, however, and young people are choosing to live and stay in Cornwall, so while the STP should plan for the ageing population needs it should not do so exclusively.
- Accessibility issues -Cornwall’s size and geography, with its largely remote rural areas interspersed with small urban centres and limited public transport availability, makes service accessibility a significant challenge for the health and care system.
- Seasonal demand-As a popular tourist destination, the number of people in Cornwall surges to four times the resident population in the summer, resulting in high seasonal demand for primary care and urgent care health services.
- Poor start in life–Some children are experiencing poor health in their early years which has a significant impact on their future health outcomes,
- Increased proportion of lives spent in poor health -People are living longer but the length of time that they remain healthy is not increasing.
- Disease prevalence, co-morbidity and frailty -Nearly 500 people die early from heart disease and stroke each year; 10% of people aged over 65 years have frailty.
- Significant health inequalities -There are stark disparities in outcomes between areas of affluence and deprivation in Cornwall.

Therefore in the STP we recognise that there are significant health inequalities across different communities within Cornwall and the Isles of Scilly which we need to address. The plan signals a strong focus on tackling these gaps, particularly for our poorest areas which experience some of the worst health outcomes. Our population is ageing, as people are living longer, but often in poor health with disabilities.

The Joint Strategic Needs Assessment (JSNA) provides us with a process to identify and monitor changes in local health and wellbeing needs and inequalities of the local population. We have used available equality data to show current issues in Cornwall and the Isles of Scilly.
Safeguarding vulnerable adults will remain a priority for all the services involved in the transformation. Although there will be no direct changes to the current policy and processes to protect vulnerable adults, improving system wide integration of health and care will have a positive impact on identifying and supporting vulnerable adults.

Some groups in our population are known to have poor health outcomes and multiple complex needs, leading to high health service use. These groups include people with chaotic lifestyles which could include alcohol or drug misuse, mental health problems, people in contact with the justice system, ex-offenders and rough sleepers.

- The STP includes plans to provide better support for people with mental health problems and complex needs via integrated community teams and prevention approaches.
- The plans for more focus and resources in primary, community and social care – including the voluntary and carers sector do not currently consider community safety issues.
- The STP recognises the impact of domestic abuse on people and communities in Cornwall.
- People with complex needs may frequently present at emergency departments, improvement of partnership work could improve contact with the right professional.
- The Community Safety partnership has not been a key stakeholder of the STP to date.

10. Options available

The process for developing and appraising the options as part of the development for the new model of care and the ACS are set out in section 3 above

11. Supporting Information (Appendices)

Appendix 1: Devolution Plan on a Page

12. Background Papers

None

13. Approval and clearance

All reports:

<table>
<thead>
<tr>
<th>Final report sign offs</th>
<th>This report has been cleared by (or mark not required if appropriate)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance/Legal (Required for all reports)</td>
<td>Mark Pearce</td>
<td>12/01/18</td>
</tr>
<tr>
<td>Finance</td>
<td>Gareth Rees</td>
<td>8/1/18</td>
</tr>
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</table>
(Required for all reports)

<table>
<thead>
<tr>
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<th>Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Equality and Diversity</td>
<td></td>
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<tr>
<td>Service Director (Required for all reports)</td>
<td>Jonathan Price</td>
<td>16.01.2018</td>
</tr>
<tr>
<td>Strategic Director (If required)</td>
<td>Trevor Doughty</td>
<td>16.10.2018</td>
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