**Appendix 1**

# SOMERSET SUSTAINABILITY AND TRANSFORMATION PLAN

# PROPOSAL FOR THE DEVELOPMENT OF A JOINT COMMISSIONING FUNCTION

Version 2 – July 2017

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## APPENDICES

## EXECUTIVE SUMMARY

Through its Sustainability and Transformation Plan, health and social care leaders in Somerset have agreed to develop one Accountable Care System for the county by 2019. It has also been agreed that this will require joint commissioning arrangements to be developed. This paper sets out proposals for the development of these joint arrangements.

Currently the commissioning of health and social care services spans across three organisations: the Somerset Clinical Commissioning Group (CCG), Somerset County Council (SCC) and NHS England (NHSE). This paper puts forward and reviews the options available, under current legislation, to bring together a joint commissioning function for Somerset.

The paper reviews six options and, following an options appraisal, proposes an option to develop a new delivery vehicle, combined with an integrated staffing structure and greater use of pooled budget arrangements through a Section 75 agreement.

This paper also sets out a suggested timescale for further work and decision making. It is proposed that subject to this proposal being agreed by the CCG Governing Body, NHS England and the Somerset County Council Cabinet in July 2017, a more detailed Business Case will be developed in consultation with staff and leaders within the Somerset health, public health and social care system. This would be considered by relevant organisations for a decision to proceed in November 2017.

## 1 INTRODUCTION

1.1 The Sustainability and Transformation Plan (STP) for Somerset has agreed the following vision for health and social care in Somerset:

> **People in Somerset will be encouraged to stay healthy and well through a focus on:**
>
> - Building support for people in our local communities and neighbourhoods
> - Supporting healthy lifestyle choices to be easier choices
> - Supporting people to self-care and be actively engaged in managing their conditions
>
> When people need to access care or support this will be through joined up health, social care and wellbeing services. The result will be a healthier population with access to high quality care that is affordable and sustainable.

1.2 Through the Sustainability and Transformation Plan, health and social care leaders in Somerset have agreed to develop one Accountable Care System (ACS) for the county by 2019. It has been agreed that this will require joint commissioning arrangements to be in place which will have responsibility for setting the outcomes for the system.

1.3 The success of an ACS relies on many things, but strong clear and integrated commissioning is one of the firm building blocks. Current legislation and organisational form means that local organisations with a will to jointly commission for a whole health and social care system, need creative solutions in order to achieve this.

1.4 This paper specifically considers the options available for the development of a joint commissioning function across Somerset Clinical Commissioning Group (CCG), NHS England and Somerset County Council (SCC).

1.5 It recommends a preferred option, as well as proposing a plan that describes the transition to this outcome with the appropriate development of the commissioner workforce.

## 2 BACKGROUND

### Context

2.1 The Spending Review in November 2015 announced the government's plan to integrate health and social care services by 2020. Each part of the country will develop plans for this by 2017, to be implemented by 2020. There is a need, now more than ever, to make best use of public money. Joint commissioning can contribute to this, ensuring shared leadership, working towards shared priorities and outcomes.

2.2 There is a need for the NHS in Somerset to make approximately £600m in efficiency savings by 2021. Added to this, there is also an expectation that social care budgets will become increasingly more pressured, given the increasing needs of the population. Stronger and more efficient ways of commissioning and delivering care must be identified.

**The Benefits and Risks of Joint Commissioning**

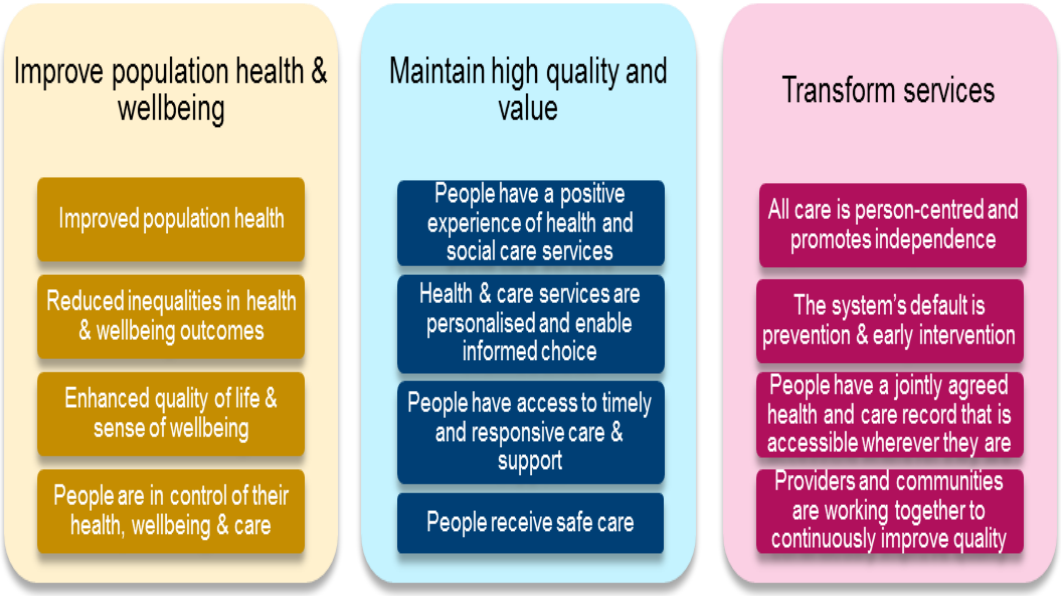
2.3 Table 1 outlines the overall benefits and risks of developing a joint commissioning function; the specific benefits and risks of each option have been identified in the options appraisal.

**Table 1: Showing the benefits and risks associated with developing a joint commissioning function**

| Benefits of integrating | Risks of integrating |
|---|---|
| A unified commissioner function with a single decision making process | Complex decision-making processes |
| Maximise the opportunities in the financial regimen for system gain | Differences in the financial regimen drive confusion and add complexity |
| Reduced duplication of organisational running costs | Additional short term costs could be incurred e.g. Excess Mileage |
| Clarity and certainty to commissioning staff | Uncertainty to staff who don't have a commissioning role |
| 'Pooling' and maximising available commissioning skills | May be additional short term overheads to manage tactical and operational commissioning |
| New perspectives, skills and experience bring significant opportunities for strong commissioning | The joint commissioning function is weakened due to significant loss of organisational knowledge |

2.4 There is an increasing emphasis on the delivery of improved outcomes via health and care organisations working together within locally determined organisational forms, and there is an opportunity to reform the commissioning incentives to achieve these objectives. Three core themes have been developed by health, social care and public health commissioners and, subject to further review and engagement, will be used as framework to develop the expected outcomes for the whole population of Somerset (Figure 1).

**Figure 1: Somerset Draft Outcomes Framework: Core Themes and Measures**




### Current Position – Joint Commissioning

2.5 The CCG and SCC already have a firm foundation to build upon, with a local history of joining up commissioning in targeted areas through Section 75 arrangements, joint posts, and since 2014 through the Somerset Better Care Fund (BCF) initiative. Appendix 1 sets out areas of current joint commissioning.

2.6 There are already some joint governance arrangements in place which encourage joint working and which can be developed further to support joint commissioning, such as:

- the Somerset Health and Wellbeing Board
- a Joint Commissioning Board
- STP governance arrangements including a Programme Executive/Oversight Group and system Steering Groups and work streams.

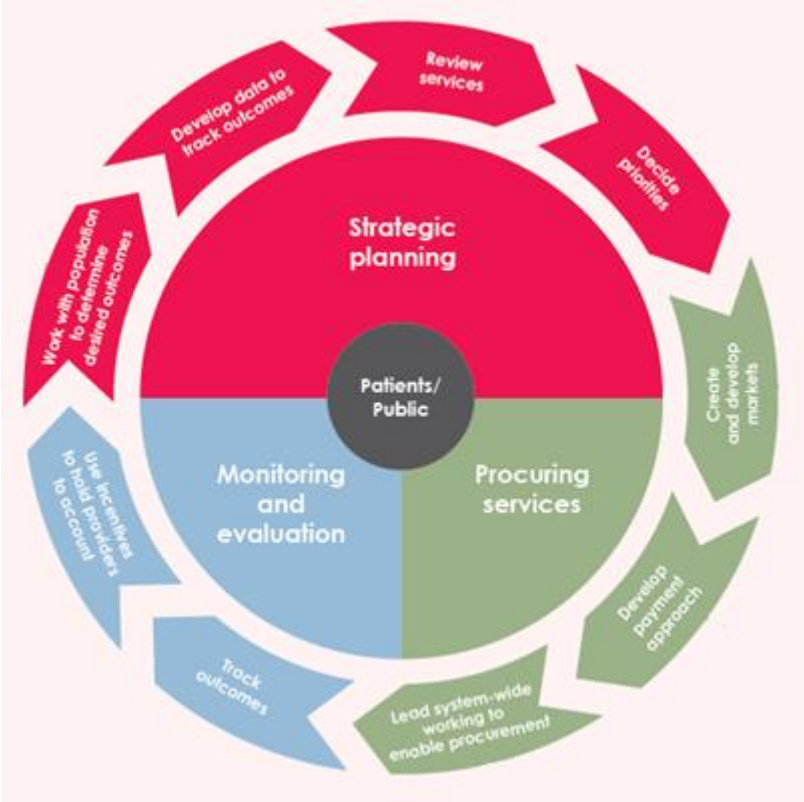
## 3 A SHARED VIEW OF COMMISSIONING

### The Commissioning Cycle

3.1 The commissioning cycle illustrated in Figure 2 shows the range of commissioning functions that could be joined up. Each step of the cycle can be applied to a joint commissioning approach. Whilst this commissioning cycle is recognised by both local authorities and the NHS, the development of joint

commissioning arrangements will not be without challenge, given the differences in the approach to commissioning procurement and contracting between the NHS and local authorities.

**Figure 2: Outcomes Based Commissioning Cycle**




**Defining Joint Commissioning**

3.2 Joint commissioning can be broadly described as the coming together of organisations in the form of a 'partnership, alliance or other collaboration' to take joint responsibility for commissioning of a set of services.

3.3 This is likely to involve organisations working in partnership at all stages of the commissioning process, from the assessment of needs, to the planning and procuring of services, the decision making processes and the monitoring of outcomes. A study undertaken by *Glasby et al* in 2013 highlighted that although arrangements may vary significantly there are a set of features common to all joint commissioning which include:

- *Formalised structures:* often through the development of formally integrated organisations or management teams
- *Pooled budgets*: a shared budget which is associated with a particular population or disease group with needs that span the responsibilities of both organisations
- *Lead commissioning arrangements*: one partner often takes the lead on commissioning a particular service to avoid duplication

- *Co-location*: often involves the co-location of relevant staff from each organisation

- *Hybrid roles*: joint commissioning can involve the appointment of staff who span more than one organisation, often at a senior level

3.4 Specific operational and legal enabling mechanisms are required to support joint commissioning, including:

- Use of Section 75 of the NHS Act 2006 which gave PCTs (and subsequently Clinical Commissioning Groups) and local authorities legal powers to enter into integrated and lead commissioning roles

- Aligned budgets in agreed service areas

- Pooled budgets – use of Section 75 enabling NHS bodies and local authorities to create pooled budgets using contributions from their individual organisations. However, Section 75 does not allow for all health and social care services to be included within a joint fund. Further details are set out in Section 5.9 – 5.10.

**Understanding the Difference between Strategic Commissioning, Tactical Commissioning and Operational Commissioning**

*Strategic commissioning*

3.5 Strategic commissioning is the term used for all the activities involved in:

- assessing and forecasting needs

- identifying the desired health and wellbeing outcomes for the population

- being responsible for assurance and oversight of statutory responsibilities

- linking investment to agreed outcomes

- engaging and consulting with the public and services users

- monitoring and performance managing the contract/s with the Accountable Provider Organisation in line with the outcome requirements

3.6 A Joint Commissioning function in Somerset would require the CCG, NHS England and SCC to work together using a pooled budget through a Section 75 agreement.

3.7 Leaders within Somerset recognise that there are strategic, tactical and operational commissioning functions within the emerging ACS.

*Functions of strategic commissioning*

3.8 The proposed functions which would be the responsibility of the joint commissioners are set out in Table 2.

**Table 2: Showing the different levels of commissioning within the emerging Accountable Care System (ACS)**

| | **Strategic Commissioning** |
|---|---|
| | Longer term strategic planning for the health and wellbeing of the population, in line with the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy<br><br>The strategic commissioning function has responsibility to advocate on behalf of the population and influence across the wider determinants of health: for example, education, housing, employment etc, as well as influencing and commissioning across and beyond Somerset's boundaries, including national lobbying.<br><br>The strategic commissioning function is responsible for defining the outcomes required for the population from the system, informed by the JSNA. As the ACS matures, it would be responsible for developing and managing the outcomes and contractual framework for a capitated outcomes-based contract.<br><br>Through shared leadership, the system would need to ensure achievement of financial balance and future sustainability and the strategic commissioning function would be required to assure this is in place.<br><br>The strategic commissioning function within the system would manage strategic risks, assure compliance with policy and regulatory frameworks and foster a culture of continuous improvement across the system. Assurance on a range of areas would be required such as:<br><br>• Quality and patient safety<br>• Emergency planning and business continuity<br>• Safeguarding |
| | **Tactical Commissioning** |
| | Tactical commissioning relates to the commissioning of services which enhance and support core health, public health and social care services. They are often provided by a wide range of providers, including social enterprises and the voluntary and community sector, and usually cover a specific population or geographical area.<br><br>As the Accountable Care System matures and moves toward a capitated, outcome-based approach, it is envisaged that many tactical commissioning responsibilities will become the responsibility of the Accountable Provider Organisation. |

| | **Operational Commissioning** |
|---|---|
| | Operational commissioning refers largely to decisions taken on a single individual level: they include individual packages of care and decisions on individual referral and treatment pathways that are within scope of current policy. |

3.9 The Joint Commissioning function would need to undertake strategic, tactical and some operational commissioning in the early stages of the ACS, while an Accountable Provider Organisation (APO) is developing. It is acknowledged that some of the tactical and operational commissioning could then become the responsibility of the APO in the longer term.

## 4 OPTIONS FOR THE DEVELOPMENT OF A JOINT COMMISSIONING FUNCTION

4.1 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

4.2 These broad options have been considered and developed into six more detailed options, to be taken forward into an options appraisal for the development of joint strategic commissioning arrangements in Somerset. Each of the six options is detailed in Table 3.

**Table 3: Six options considered in the options appraisal**

| | |
|---|---|
| **Option 1** | Do nothing option – commissioning arrangements remain separate, split between the two organisations with separate decision-making |
| **Option 2** | Greater use of existing funding alignment arrangements, such as Section 75/Better Care Fund |
| **Option 3** | The CCG acts as lead commissioner for all health, social care and public health commissioning |
| **Option 4** | The Local Authority as lead commissioner for all health, social care and public health commissioning |
| **Option 5** | The Local Authority acts as lead commissioner for Children and Young Peoples services. The CCG acts as lead commissioner for Adult Services |
| **Option 6** | Commissioning of health, social care and public health services is undertaken through a new vehicle such as a Joint Health and Care Board |

## Options Appraisal

4.3 A detailed appraisal of these options has been undertaken using The Chartered Institute of Public Finance and Accountancy principles. An options matrix has been developed that has assessed each option against the following aims:

- achievement of the outcomes set out by the system through the Sustainability and Transformation Plan
- achievement of straightforward and acceptable governance under current legislation
- achievement of financial advantages for the public purse
- making the most effective use of the workforce skills and experience in Somerset.

4.4 The detailed options appraisal is set out in Appendix 2 but Table 4 below summarises the main findings.

## Table 4: Summary of the Results of the Detailed Options Appraisal

| Option | Score | Options appraisal summary |
|---|---|---|
| **Option 1**<br>Do nothing option – commissioning arrangements remain separate, split between the two organisations with separate decision-making | 31 | This option is least disruptive for organisations but less likely to achieve significant improvements in population health outcomes or efficiency for the public purse. This option does not make best use of the different commissioning skills and expertise across the workforce. It is unlikely that the relationship between commissioners will improve as this perpetuates the organisational silos. |
| **Option 2**<br>Greater use of existing funding alignment arrangements, such as Section 75/Better Care Fund | 48 | This option requires no significant changes to current structures. It would be entirely possible for commissioners to enter into new or expanded Section 75 agreements to pool budgets covering a wider range of services and more joint commissioning posts could be established to support this.<br><br>Without more collaborative decision making in place also, this option is clumsy, requiring the same decisions to be taken to separate boards. |
| **Option 3**<br>The CCG acts as lead commissioner for all health, social care and public health commissioning | 50 | Lead responsibility for strategic commissioning is delegated to the CCG. The clear advantage of this is that there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget.<br><br>Lead commissioner arrangements are already used between the CCGs and local authority (e.g. Integrated Community Equipment Service). This option is arguably more suited to commissioning of specific services rather than complete delegated authority for statutory duties. |
| **Option 4**<br>The Local Authority as lead commissioner for all health, social care and public health commissioning | 54 | Lead responsibility for strategic commissioning is delegated to the County Council. The clear advantage of this is that there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget. Lead commissioner arrangements are already used between the CCGs and local authority (e.g. Integrated Community Equipment Service). This option is arguably more suited to commissioning of specific services rather than complete delegated authority for statutory duties. |
| **Option 5**<br>The Local Authority acts as lead commissioner for Children & Young Peoples services, the CCG acts as lead commissioner for Adult Services | 37 | This option makes good use of the skills and knowledge of the existing workforce and would require little organisation disruption; however, it poses a significant risk of detaching children and adults services, thereby not achieving the advantages that come about through a whole population approach or capitated outcomes-based contract. This option could significantly hinder the smooth transition between children and adults services. |
| **Option 6**<br>Joint commissioning of health, social care and public health services is undertaken through a new vehicle such as an Joint Health and Care Board | 57 | This option is to establish a new joint vehicle to be the single commissioner. The statutory commissioning organisations would retain their respective responsibilities but the organisations would take decisions at the same time through a joint meeting of the CCG Governing Body and Cabinet. This joint Board would control a significant pooled budget under a Section 75 Agreement. The CCG and local authorities would retain their respective statutory responsibilities and would therefore not require delegated authority. This new governance could be supported by a single combined officer base from the two organisations, making good use of the skills and providing options for greater efficiency.<br><br>This option could involve an extensive organisational change however, there could be an evolutionally process that would not involve a complete upheaval of existing organisations in one go. |

## Proposed Preferred Option

4.5 Taking into account the outcome of the options appraisal, the proposed preferred option is Option 6: the development of a new vehicle bringing together the commissioning of health, public health and social care, whilst retaining organisational statutory responsibilities. The rationale for this recommendation is set out below.

*Achievement of outcomes set out by the system*

4.6 The strength of a single vision and a single robust commissioning function could bring far greater focus to commissioning for the needs of the population both now and in the future.

4.7 This option establishes a Somerset Together Health and Care Board, bringing together the CCG Governing Body, NHS England and the SCC Cabinet to be at the heart of the joint commissioning function. This option could strengthen commissioning against population needs, in line with the JSNA and Health and Wellbeing Strategy. The degree to which this option could influence outcomes will be determined by the effectiveness of the shared leadership across the system, including confirmation and clarity of NHS England's role within the arrangement.

4.8 This model offers the widest possible coordination of services across the whole Health and Wellbeing system.

*Achievement of acceptable governance under current legislation*

4.9 The bringing together of the SCC Cabinet and the CCG Governing Body into a Somerset Together Health and Care Board would require robust governance structures to be established. It is important that the structures can operate within the complex legal framework of both organisations, preferably without having to have delegated authority for statutory responsibilities.

4.10 This option has the added benefit of increasing local democratic accountability within the NHS as well as maintaining strong clinical engagement and leadership within health and social care.

*Achievement of financial advantages*

4.11 This option has the ability to achieve savings in overheads and staffing by reducing duplication, estate and travel and enhancing shared back office functions.

4.12 Commissioning across the population could incentivise increased investment in preventative work thereby bringing about greater efficiencies in the longer term. This option enables efficiencies to be made through integration of the management support and by having the potential to pool wider budgets to gain the greatest health and wellbeing benefit.

*Making the best use of workforce skills and experience*

4.13 This option would require an integrated commissioning construct that should draw on the skills and expertise right across the health and wellbeing system in Somerset. This could provide an exciting employment and development opportunity for commissioners, providing a breadth of experience.

4.14 This option would make best use of the skills and resources of the county as a whole, building on the community development and communication and engagement skills across the system.

## 5 THE PROPOSED MODEL

### Governance

5.1 Appendix 3 sets out the proposed Commissioning Governance structure for the health, public health and social care system. This would sit within the wider Somerset partnership structures within the ACS as seen in Appendix 4.

5.2 This option uses joint decision making through a joint meeting of the CCG Governing Body, NHS England and SCC Cabinet. The meetings would be held in public and would need to satisfy the decision-making arrangements and governance of each of the organisations. The organisations would retain their statutory responsibilities in line with the current legislative requirements. It is envisaged that the boards would also need to continue to meet separately for governance reasons and to manage business that may be outside of the joint commissioning. However, it is likely that the need for separate meetings would be reduced.

5.3 Any proposals for joint commissioning arrangements which result in a change to the role of the CCG Governing Body or SCC would require amendments to the appropriate constitutions. For SCC, these changes would need to be approved by Full Council. For the CCG any changes would need to be agreed with NHS England.

5.4 NHS England would need to be satisfied that the constitution complies with the particular requirements of the NHS Act 2006. The submission would need to be discussed with relevant NHS England regional leads and should include:

- reasons why the variation is being sought
- assurance that member practices have agreed to the proposed changes
- assurance that stakeholders have been consulted if required
- assurance that the CCG has considered the need for legal advice on the implications of the proposed changes
- a complete impact assessment of the changes

5.5 It is proposed that the Health and Wellbeing Board continues to undertake its statutory duties to produce a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This Board will, as now, have an influencing role across the system to ensure all organisations are aligning their strategic plans with the needs of the population and the priorities in the Health and Wellbeing Strategy.

**Scope of joint commissioning**

5.6 Bringing the commissioning function together would enable a joint approach to a wide range of issues impacting Somerset residents and could significantly benefit the Somerset population, but particularly vulnerable people who experience multiple issues and inequalities. The aspiration should be for the scope of joint commissioning to be as broad as possible in order to gain maximum gain for the population.

5.7 To maximise the opportunities for joint planning, cost effective commissioning and the development of integrated pathways of care, it would be the intention to use pooled budgets across the following areas. It should be noted that there will need to be a phased approach to the pooling of budgets as the ACS matures:

- all health budgets currently held by Somerset CCG, with the exceptions of any legal exclusions
- NHSE Specialised and Primary Care Commissioning budgets
- all adult and children social care budgets, with the exceptions of any legal exclusions
- public health commissioning budgets

**Financial considerations**

5.8 Whilst the joint board provides the opportunity for the organisations to take the same decisions simultaneously, there is still a need to pool potentially significant budgets through a Section 75 agreement in order to commission jointly. This would build on the existing pooled budget arrangements currently in place in the county but have the added benefit of having much clearer transparency through the work of one single officer base.

Requirements for Section 75 under the current regulations are detailed below:

- to improve the provision of services
- to have a written agreement with agreed aims and objectives
- to identify the functions to be supported and the people who will benefit
- agreement on contributions to the Fund
- an agreed length of the agreement

- agreed hosting arrangements and a pooled fund manager
- plans for managing over and underspends
- exit arrangements

5.9 An agreement on scope of budgets to be pooled over time needs to be more fully explored in the full business case.

*Exclusions from S75 Agreements*

5.10 The use of Section 75 enables NHS bodies and local authorities to create pooled budgets using contributions from their individual organisations. However, Section 75 does *not* allow for all health and social care services to be included within a joint fund. For example, NHS organisations are prevented from delegating the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services

5.11 Whilst local authorities can delegate a broad range of their services, the legislation sets out some detailed exclusions. Given that both NHS organisations and local authorities can utilise these arrangements, it is not considered that restrictions around Section 75 should hinder any approach we wish to take towards creating joint commissioning.

5.12 Given that all functions cannot yet be included within a pooled budget, other arrangements will need to be established to compliment the Section 75 agreements. Possible solutions to be discussed may include:

- aligned budgets - ensuring transparency of remaining budgets and ensuring alignment to overall objectives
- grants to transfer money between organisations
- lead/joint commissioning arrangements for some services

*Audit and Right of Access*

5.13 Where a pooled budget is in place, one partner is required to act as the host (Host Partner) and becomes responsible for the budgets, accounts and audits, as well as for paying suppliers. This would reduce transactional costs and bureaucracy but would need agreement by both parties. Each organisation would need to ensure that the relevant regulatory requirements relating to their funding stream are met when funding decisions are made.

5.14 The parties will each have responsibilities for audit and so the arrangement needs to provide for the responsibilities of the Host Partner relating to audit and the right of internal and external auditors to be given access to anything they need to carry out their duties.

*Risks*

5.15 The treatment of risks from services commissioned from the pool will need to be agreed on with the establishment of the fund. Risks arising from services outside of the pooled fund will also need formal agreement on any risk share/gain share. Current risk share arrangements with providers (2017/18 to 2018/19) may need to be incorporated in the short term.

*VAT*

5.16 Local authorities and the NHS have different VAT treatments. Professional advice on the general VAT implications of developing a joint commissioning function has been sought. This advice suggests there may be VAT benefits to particular options for joint commissioning and these have been fed into the options appraisal. Further work would need to be undertaken to identify the extent to the potential VAT benefit (or indeed any VAT implications to any of the organisations) of the specific option to be worked up into a full business case.

*Finance workforce*

5.17 To deliver the joint strategy through a pooled budget, the finance teams from the organisations will need to work together, either through joint posts or an integrated back office function. There is a need for a greater understanding between the NHS and local authority staff regarding the respective financial regulations and processes of the organisations.

**Information Governance**

5.18 Since the establishment of Somerset CCG, a lot of work has been undertaken to ensure that, where possible, information sharing is integrated across the county. A countywide Information Sharing Protocol is in place which all health partners and SCC are signatories to and which has ensured there is a high-level, consistent approach for information governance for all participating agencies to refer to, when establishing second level information sharing agreements for specific initiatives and activities.

5.19 In accordance with the requirements of information law and 'best practice' guidance, this protocol provides a formal agreement between agencies to share information for a range of specific purposes, such as direct care or to safeguard and promote the wellbeing of the Somerset patient population, wherever they reside. Any information sharing is carried out in the context of recognising duties of confidentiality and the right to privacy in respect of patient's personal information.

5.20 Within a joint commissioning function, the aim will be to continue to promote a consistent approach to the sharing of information that will benefit individuals and services whist protecting the people that information is about.

5.21 Sharing patient information must always be within the legitimate activities undertaken by an organisation in providing a service to the public and with a legal basis for sharing. Each of the statutory bodies, as data controllers, will need to ensure they understand and retain their responsibilities as legal entities, taking into account relevant legislation such as the Data Protection and Freedom of Information Acts.

5.22 Work has begun to understand how we can best streamline our processes so that, wherever possible, all organisations adopt a common and consistent approach to information sharing and management and we enable far greater integrated decision making in the future.

5.23 There has also been considerable work to determine how to appropriately link health and social care data to support integrated commissioning decision making. This will need to be further developed in our work with NHS Digital nationally. NHS Digital controls the flow of national NHS statistical data sets. Both the CCG and SCC complete the Information Governance Toolkit which underpins the development of systems and processes to manage information governance.

**Workforce**

5.24 In order to support the commissioning, a joint management framework would need to be established. Appendix 5 shows a proposed integrated framework which brings the commissioners together in order to commission against population needs, in line with the JSNA and Health and Wellbeing Strategy. Whilst Somerset has a few examples of joint commissioning posts, the lack of an integrated officer base has arguably been one of the reasons for tension within the current joint commissioning and pooled budget arrangements.

5.25 In the longer term, there will need to be consideration given to which commissioning functions need to stay with the joint commissioning function and which need to be the responsibility of the APO. Initial thoughts on this are set out in Appendix 6 but will need to be continued thought throughout the development of the ACS. In part, this function list will help determine the movement of workforce required. In time, the officer base could harmonise employment but this is not considered a priority initially.

5.26 In addition to a joint commissioning function, there is scope to develop a system-wide business unit, offering the potential to integrate core functions such as business intelligence and communications across the system. This approach could not only drive greater efficiencies in the system but makes best use of the skills of the current workforce and ensures that strategic, tactical and operational commissioning use the best intelligence available.

5.27 Table 5 shows the potential functions that could be included in the business unit highlighting those that may be needed for the different levels of commissioning.

**Table 5: Possible functions that could be included in the joint business unit**

| Strategic, Tactical and Operational Commissioning | Strategic Commissioning Function |
|---|---|
| Business Intelligence | Finance |
| One Public Estate | HR & OD |
| Communications & engagement | IT |
| | Corporate Governance |
| | Legal services |
| | Quality & patient safety |
| | Procurement |

*HR Process*

5.28 Each organisation will be required to carry out a piece of work to identify employees who would form part of the joint commissioning function.

5.29 Following this, employees will be written to, describing how their functions align. As this paper has described, there will be no new organisation as a result of the changes, so those employees that are aligned to the joint commissioning function will continue to work for either the CCG, NHS England or SCC. This means that there will be no TUPE implications. However, there may be a new organisational agreement developed in order to support joint working arrangements across both organisations. This is likely to result in:

- different job roles and job descriptions
- a different culture and way of working
- a potential change of base to support joint working and alignment of roles
- different system level relationships with stakeholders

5.30 It is recognised that bringing together employees from the NHS and local authority will mean that employees will have different terms and conditions of employment. However, as employees are not TUPE transferring into a new organisation, respective terms and conditions would remain the same.

5.31 Throughout this change process, both the CCG, NHS England and SCC will ensure that the HR principles laid out below will be followed:

- consult and engage at the earliest opportunity with employees and their representatives and make sure all parties are kept fully informed and supported during the change process
- promote transparency, equitability and fairness in all transfer, selection and appointment processes

- ensure professional and respectful behaviour towards all employees moving between organisations
- ensure the consistent treatment of all employees
- actively promote quality and diversity standards through all transfer, selection and appointment processes
- ensure full compliance with employment legislation
- undertake early engagement with employees and their representatives to enable effective and sustainable change
- ensure equality impact assessments take place when required
- ensure that all reasonable steps are taken to avoid redundancies and work to ensure that valuable skills and experience is retained

**Co-Location**

5.32 In order to achieve the joint commissioning function, the officer construct would need to change significantly, with the coming together of teams and individuals from different backgrounds and cultures. Evidence suggests that co-location of teams is an important element in achieving this.

5.33 Giving consideration to the estate available across Somerset there would be significant benefits in centralising the commissioning function. The obvious options to be considered are the current headquarters of the two organisations – for example, County Hall, Taunton and Wynford House, Yeovil. The solution would need to provide sufficient capacity for commissioning staff. An options appraisal and business case would need to be conducted in Phase 2 of the project, subject to there being a decision to proceed.

**Principles, Standards and Conflict Resolution**

5.34 The STP has already identified and agreed 14 principles for the new ACS as set out in Appendix 7. These are equally as relevant for the joint commissioning function as they are for the rest of the system and therefore it is proposed that they should also be adopted for this workstream of the STP.

5.35 In 1994, the Standards Committee of Public Life set out seven standards of behaviour which remain widely used today. The standards, as seen below, are entirely relevant in this context and form the basis for the behaviours that would be required of the organisations and staff whilst forming and working within a new strategic commissioning function.

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

5.36 Each of the organisations has its own culture and ways of working; at times of integration, it is important that trust is built between the organisations and staff. It should be recognised that there will be challenging times and it is important to agree that is it acceptable to appropriately challenge each other where the Standards of Public Life are not being adhered to.

## 6 PROPOSED MOBILISATION PLAN

6.1 An indicative timeline for implementation of a Joint Commissioning function is attached as Appendix 8. This indicates a decision point in July 2017 followed by a four phased approach.

### Phase 1: Decision Phase

6.2 This phase runs from May to July 2017. During this phase the emphasis would be on continuing to develop the thinking regarding what is needed for the joint commissioning function, continuing to consult and discuss initial proposals with elected members, Governing Body Members, staff and the wider health and social care system. During this phase, legal advice would also need to be obtained, particularly around the pooling of budgets, VAT implications and any legal requirements/considerations of the joint board.

6.3 There will need to be early discussions with all organisations within the health and social care system to get clarity across the system on the roles of a strategic, tactical and operational commissioner. The system will also need to

consider the willingness and options for the development of a shared business unit as proposed in Table 5.

6.4 This phase would conclude with formal proposals being put to the CCG Governing Body and SCC Cabinet in July, for a decision on the preferred option and to proceed to a full business case. During this phase, discussion would also be required with NHS England to more fully understand their involvement going forward.

**Phase 2: Development of full business case and shadow working**

6.5 This phase is proposed to run from July to November 2017. During this time a full business case will be developed for the preferred option and agreed by the relevant organisations. This business case will be developed in consultation with staff and leaders within the health, public health and social care system. It is proposed that the final business case is considered by the relevant organisations in November 2017 and a decision taken to proceed to Phase 3.

6.6 This phase will consider the arrangements required for the formal establishment and running of the Somerset Together Health and Care Board and will run one meeting in shadow form to help develop the relationships between the boards and test out any new operating procedures. Any organisational constitutional changes will be identified during this phase.

6.7 Shadow working arrangements would provide an opportunity for both organisations to focus jointly on development of the Outcomes Framework and progression towards an ACS.

6.8 A detailed workforce assessment will need to be undertaken by July 2017, building on the work already done, to establish those staff across the organisations that will form the joint commissioning function. It should be noted that some staff with responsibility for tactical and operational commissioning may need to remain with this commissioning function until such a time whereby their function is passed over to the new APO.

6.9 Workforce and team development will be essential during this phase and beyond to create new integrated teams and start to address differences in culture and ways of doing business. A local Commissioning Leadership Academy programme is already underway, which could be a significant step in supporting commissioners from across the system to work together on specific issues.

6.10 An informal approach to the integration of executive teams and officer groups will be started during this phase, enabling joint senior team meetings, shadowing of staff across organisations.

**Phase 3: Co-location, joining up of IT and development of the business unit**

6.11 This phase is proposed to run from November to April 2018. This is the mobilisation phase; as early as possible, commissioning teams will be moved

to one location with relevant teams physically sitting together and an integrated IT solution achieved.

6.12 Similarly, the business unit will be formed, for the interim, while the system is transforming. This may include staff who will ultimately will be placed within the APO.

6.13 During this phase, any changes to relevant constitutions will need to be formally agreed, following engagement with relevant stakeholders including GP member practices. In addition, the new Somerset Together Health and Care Board will hold its inaugural meeting formally in public.

6.14 The aim, by the end of this phase, is for:

- the governance structures to have been tested and, where needed, organisational constitutions changed
- the first formal meeting of the new Somerset Together Health and Care Board to have taken place
- all joint commissioners to be in one office-base
- new, integrated senior leadership arrangement in place
- workforce to be integrated together in appropriate teams
- the new function and business unit to be using one IT strategy
- an information governance framework in place

**Phase 4: Full implementation**

6.15 The phase will take place from April 2018 and beyond. It will be a phase of consolidating the new model and reviewing opportunities for the future as the national legislative framework allows and the ACS develops.

## 7 SUMMARY AND RECOMMENDATIONS

7.1 This paper has set out options for the development of a new joint commissioning function for Somerset as an integral part of developing an ACS by 2019.

7.2 The paper proposes the development of a new vehicle to lead the joint commissioning of health, public health and social care, whilst retaining organisational statutory responsibilities. This approach makes much greater use of the power to develop pooled budget arrangements through Section 75 agreements and enables us to make use of the commissioning skills and experience across the two organisations through a joint management arrangement.

7.3 The Somerset CCG and SCC Cabinet are asked to approve the recommended option and approach in principle, and request that a more detailed business case is developed for further consideration in November 2017. NHS England is asked to consider this proposal as part of a phased approach towards an ACS for Somerset by April 2019.

*References:*

- *Integrated Commissioning to support Joined up care, better health and better value – draft discussion paper (C Parry)*
- *The Kings Fund – Place-based systems of care. Particularly pages 35 to 38*
- *The Kings Fund – Options for Integrated Commissioning – Beyond Barker. Particularly pages 39 to 55*
- *Exploring Strategic Commissioning Models – A discussion paper*
- *Faulty by Design. The state of public-service commissioning – Reform*
- *Need to Nurture – Outcomes-based Commissioning in the NHS*
- *CIPFA Options Appraisal Guidance*

**Appendix 1**

## Somerset CCG and Somerset County Council

## Joint Commissioned Services/budgets/other

| Description | Relationship | Budget | Comments |
|---|---|---|---|
| Integrated Community Equipment Store | County Council is the lead commissioner of a joint contract | Pooled budget 50/50 split<br>£1,039,609 each<br>Section 75 agreement? | Overseen by JCB |
| Carers Service | County Council is the lead commissioner of a joint contract | Pooled Budget<br>50/50 split<br>£203,500 each<br>Section 75 agreement? | Overseen by JCB |
| Learning Disabilities | County Council is the lead<br>Joint LD manager appointment hosted by County Council | Pooled budget<br>75/25 split<br>CCG contribution - £16,904,490<br>Section 75 agreement | Overseen by JCB |
| Mental Health | Joint MH manager appointment hosted by CCG | Pooled budget for some services e.g. CAMHS<br>Section 75 agreement | Overseen by JCB<br>(On CCG Schedule – Mental illness specific grant contribution £106,225 and Personal Care £311,525) |
| Reablement | Under Better Care Fund – Section 75 agreement | £14,305,000<br>– Section 75 agreement | HWB agree strategic direction of fund<br>Overseen by JCB |
| Housing adaptations | Under Better Care Fund | £3,466,000<br>– Section 75 agreement | HWB agree strategic direction of fund<br>Overseen by JCB |
| Improved DTOC arrangements | Under Better Care Fund | Up to £3m<br>– Section 75 agreement | HWB agree strategic direction of fund |
| Person Centric Care | Under Better Care Fund | £20,908,000<br>– Section 75 agreement | HWB agree strategic direction of fund |

**Appendix 2**

## Decision Matrix Tool

## Development of a Joint Commissioning Function

| Options | Proposal |
|---|---|
| **Option 1 – Retain existing Strategic commissioning arrangements**<br><br>**Aggregated Score = 31** | • Sovereignty of organisations remains the same<br>• Commissioning and officer arrangements remain as current, embedded in separate organisations<br>• Existing lead organisation and pooled budget arrangements remain in place<br>• Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy |
| **Option 2 – Increased use of existing legal arrangements e.g. BCF/Section 75 agreement**<br><br>**Aggregated Score = 48** | • Sovereignty of organisations remains the same<br>• Far greater use of a legal framework to pool resources under section 75 agreement<br>• Officer workforce remains as current embedded in separate organisations with no co-location<br>• Decision-making undertaken by separate sovereign organisations<br>• Health and Wellbeing Board would need to be enhanced to continue to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy but also to have increased responsibility to oversee significant pooled budgets |
| **Option 3 – CCG as the lead commissioner**<br><br>**Aggregated Score = 50** | • Sovereignty of organisations remains the same<br>• CCG leads the commissioning of health, social care and public health services requiring formal delegation of statutory duties from SCC to the CCG and use of a legal framework to pool resources to a far greater extent<br>• Integration and co-location of social care and public health officer workforce with CCG<br>• Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy |
| **Option 4 – SCC as the lead commissioner**<br><br>**Aggregated Score = 54** | • Sovereignty of organisations remains the same<br>• SCC leads the commissioning of health, social care and public health services requiring formal delegation of statutory duties from CCG to SCC and use of a legal framework to pool resources to a far greater extent<br>• Integration and co-location of CCG officer workforce with SCC<br>• Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy |
| **Option 5 – CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people**<br><br>**Aggregated Score = 37** | • Sovereignty of organisations remains the same<br>• Integration and co-location of officer workforce in line with population based commissioning responsibility<br>• Formal delegation of statutory duties relating to population group from CCG and SCC or use of a legal framework to pool resources to a far greater extent<br>• Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy |

| Options | Proposal |
|---|---|
| **Option 6 – Commissioning of health and social care through a new commissioning vehicle**<br><br>**Aggregated Score = 57** | • Sovereignty of organisations remains the same<br>• No formal delegation of statutory duties from CCG to the SCC **but** use of a legal framework to pool resources to a far greater extent<br>• Integration and co-location of CCG and SCC officer workforce<br>• Joint decision making through a formal joint structure with democratic and clinical involvement<br>• Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy |

**Scoring:**

| | |
|---|---|
| 1 | The model will bring significant negative impacts on this objective |
| 2 | The model will slightly negative impacts on this objective |
| 3 | The model will not impact on this objective positively or negatively |
| 4 | The model will achieve moderate improvements in this objective |
| 5 | The model will significantly benefit this objective |

## Achievement of Outcomes

| Ability of the model to: | Commission for improved population health & wellbeing outcomes | Reduce health & social inequalities | Develop well co-ordinated & seamless care | Support individuals & communities to take responsibility for their own health & wellbeing | |
|---|---|---|---|---|---|
| **Option 1 – Do nothing option** | 2. Unless we commission differently outcomes are likely to deteriorate due to funding pressures. | 2. Inequalities are currently widening, this is likely to increase | 2. Current organisational silos will not be broken down, further cost shunting likely as funding pressures increase | 3. This is unlikely to change if there is not a cultural shift across the whole system | 9 |
| **Option 2- Build on existing funding alignment arrangements** | 4. The Better Care Fund is currently narrow and over regulated nationally. It is unlikely that this option would achieve the scale and pace of change required for significant gain in population health and wellbeing. Use of the Section 75 agreement to pool funding across the two organisations could however provide a legal vehicle if it was used to maximum effect. | 4. Joint commissioning under this model is currently very service driven and less person-centred with little consideration given to social influences on health. This option could however bring about significant advancements in the joining up of commissioning across organisations and could provide a clear and strong commissioning function with a single line of accountability. To narrow health inequalities this option would need to be used at scale for a whole population budget rather than specific services and would need to be commissioned through one officer construct. | 3. This option has not broken down organisational silos to date and is unlikely to further benefit the development of well coordinated and seamless care | 3. This requires a radical shift in the commissioning and providing culture. This will only be achieved at scale through a strong strategic vision driven forward by strong commissioning. Using a Section 75 agreement to pool resources and integrate commissioning can provide a legal vehicle however it would only work with significant transformation of officer arrangements and culture to ensure the vision of increased community and individual responsibility is driven through. | 14 |

| Ability of the model to: | Commission for improved population health & wellbeing outcomes | Reduce health & social inequalities | Develop well co-ordinated & seamless care | Support individuals & communities to take responsibility for their own health & wellbeing | |
|---|---|---|---|---|---|
| **Option 3 – CCG as lead Commissioner Model** | 4. The lead commissioner model could drive more of a whole system, whole population approach to health and wellbeing improvement. The CCG as lead commissioner could restrict the benefits to the traditional People based services and have less influence over place based commissioning. | 4. This model could lead to greater accountability for tackling health and social inequalities as lines of responsibility are clearer. Services could be commissioned with a greater emphasis on the needs of vulnerable people as a more complete picture of need could be achieved. | 4. This model could achieve better co-ordination of Health and Social Care Services due to stronger and simplified commissioning. | 4. This option could foster local empowerment depending on the approach adopted by commissioners. A traditional medical model of health would be less likely to achieve this effect | 16 |
| **Option 4 - LA as the lead commissioner model** | 4. The lead commissioner option could drive more of a whole system, whole population approach to health and wellbeing improvement. The LA as lead commissioner could bring added benefits by linking the traditional people-based services with place-based commissioning. | 4. This model could lead to greater accountability for tackling health and social inequalities as lines of responsibility are clearer. Services could be commissioned with a greater emphasis on the needs of vulnerable people as a more complete picture of need could be achieved. The LA as lead could present more opportunities to align work on the medical and social influences on health to a greater extent. | 4. This model could achieve better co-ordination of a wide range of services including, traditional health and social care services. A wider range of services could be aligned and commissioned with a common vision. | 4. This option could foster local empowerment depending on the approach adopted by commissioners. This is more likely to be achieved with the LA as lead commissioner due to adoption of a more asset-based approach and greater experience in community development | 16 |

| Ability of the model to: | Commission for improved population health & wellbeing outcomes | Reduce health & social inequalities | Develop well co-ordinated & seamless care | Support individuals & communities to take responsibility for their own health & wellbeing | |
|---|---|---|---|---|---|
| **Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people** | 2. The lead commissioner option could drive more of a whole system, whole population approach to health and wellbeing improvement. However this option maintains some of the current division in the county and even extends it further around the transition of young people into adult services. | 2. This option could lead to increased age inequalities as well as inequalities in relation to deprivation. It does not recognise the importance of a Think Family approach. To tackling inequalities and the importance of the family in lifting people out of deprivation. | 3. Whilst this may help co-ordinate care for adult and children, this option is considered detrimental to the transition of young people into adult services. | 3. It is not envisaged that this option would have a significant positive or negative effect on supporting individuals to take responsibility for their own health and wellbeing. It could be argued that the separation of children and families lacks recognition of the importance of families | 10 |
| **Option 6 – A new Vehicle** | 4. This option places a new joint decision making body at the heart of the new Accountable Care System. This option could provide a strengthened commissioning function, bringing together democratic and clinical decision making. This option provides significant opportunity to influence outcomes, bringing vision across all factors that influence health. | 4. This option has the ability to join up commissioning across the whole Health and Wellbeing System, including the wider determinants of health. The degree to which the option could influence outcomes will be determined by the scope of services included in the joint commissioning function. | 5. This model could offer significant co-ordination of services across the system. The degree of clarity on commissioning arrangements could hinder the strength of commissioning achieved. | 4. This option would make best use of the skills and resources of the county as a whole, building on the community development and communication and engagements skills across the system. The degree to which these can be galvanised using a shared leadership model could restrict the benefits achieved by this option. | 17 |

## Governance Considerations

| Ability of the model to: | Provide clear and strong leadership to the new Accountable Care System | Enable local democratic and clinical engagement and accountability | Commission for a whole population using a capitated outcome-based contract | Be feasible under current legislation (Not scored | |
|---|---|---|---|---|---|
| **Option 1 – Do nothing option** | 3. Unlikely that any less or more clarity will be achieved. | 3. Unlikely to change | 1. It is unlikely that a whole system vision would be achieved using this model due to the continuation of organisational silos | This option is already in place | 7 |
| **Option 2- Build on existing funding alignment arrangements** | 3. It is not considered that this option would significant improve clear and stronger leadership of the system, it is an extension of existing arrangements | 4. BCF is currently overseen by the Health & Wellbeing Board. A much more considerable section 75 agreement could also be overseen by an enhanced Health and Wellbeing Board. Unless the Board was given considerable delegated powers, the agreement would also need to be overseen by SCC Cabinet and the CCG, possibly through a regular joint public meeting. | 4. If used at scale, this option could be used to commission a whole population capitated, outcomes-based contract, but would require significantly stronger partnership working arrangements and agreed governance | This is already feasible under current legislation but underused. | 11 |
| **Option 3 – CCG as lead Commissioner Model** | 4. This option would provide a single local body with clear commissioning responsibility. The option would not bring the whole strength of commissioning skills as some would need to remain in SCC. This option could be confrontational and not improve the relationship of the two organisations at a time when collaboration is needed more than ever | 4. If the CCG was the lead there would be a need to increase the democratic accountability of commissioning in order to enable the delegation of statutory duties. Clinical engagement and accountability would be maintained | 5. This outcome is fully achievable under this option if the CCG had delegated authority to undertake the social care and public health responsibilities | This option is considered feasible but would require significant delegation of statutory duties | 13 |

| Ability of the model to: | Provide clear and strong leadership to the new Accountable Care System | Enable local democratic and clinical engagement and accountability | Commission for a whole population using a capitated outcome-based contract | Be feasible under current legislation (Not scored | |
|---|---|---|---|---|---|
| **Option 4 - LA as the lead commissioner model** | 4. This option would provide a single local body with clear commissioning responsibility. This option could be confrontational and not improve the relationship of the two organisations at a time when collaboration is needed more than ever | 4. If the LA was the lead, local democratic accountability would be central to the commissioning of health and social care services. The process of decision-making would be aligned to the current council democratic processes. Clinical engagement and accountability would need to be carefully considered in order to maintain it | 5. This option enables system join up for all SCC and CCG commissioned services not restricted to the health, social care and public health services. This approach could commission a whole population, capitated, outcomes based contract | This option is already in place | 13 |
| **Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people** | 4. This option would provide clear and potentially specialised leadership to the system however this would not be shared leadership, it would need to be aligned between adults and children's services | 3. This would provide greater democratic accountability in children's commissioning and less in adults. | 2. This option would hinder the commissioning of a whole population, capitated, outcomes based contract. It would require collaboration across the two organisations and therefore does not take the system any closer to commissioning for the whole of Somerset. | This is already feasible under current legislation but underused. | 9 |
| **Option 6 – A new Vehicle** | 3. This option requires shared leadership across a range of partners. It would require significant restructuring and development of the Board as well as significant delegation of authority. | 5. This option could provide significant democratic and clinical accountability in decision making with the right construction of governance arrangements | 5. This option enables whole system alignment throughout the health and wellbeing system, not restricted to the health and social care services. This approach is capable of commissioning a whole population, capitated outcomes based contract but will require significant integration of the officer structures to be able to achieve it. | May need work around for some services that cannot come under a Section 75 agreement. Will require formal delegation of statutory duties | 13 |

## Officer Considerations

| Ability of the model to: | Provide one strong and robust strategic commissioning and contract management function | Create an environment of collaboration between commissioners & providers | Develop excellent commissioning skills & expertise across the system | Requires organisational reform (Not Scored) | |
|---|---|---|---|---|---|
| **Option 1 – Do nothing option** | 2. No change therefore the relationships are unlikely to improve, could deteriorate as organisational knowledge is lost | 3. Unlikely to change, this model maintains silos | 2. Little sharing of resource and expertise, as capacity in the system decreases this is likely to worsen | None needed. | 7 |
| **Option 2- Build on existing funding alignment arrangements** | 4. Significant use of the Section 75 arrangement is unlikely to achieve a stronger commissioning arrangement as this option just extends the current financial pooling further | 4. This model could be detrimental to fostering collaboration if national imperatives are imposed (e.g. BCF) that are counter to the local direction of travel. If not done under the BCF however great collaboration could be achieved through an alignment of commissioning priorities | 3. This option is unlikely to achieve significant benefits to developing skills across the system, it is an extension of the financial pooling only | This option does not require changes to the sovereignty of the different organisation but does require significant organisational change both in terms of the staffing structures and culture. | 11 |
| **Option 3 – CCG as lead Commissioner Model** | 4. This option is likely to provide a stronger single voice for commissioning however it would be more limited to health and social care and less likely to maximise the opportunities to influence the wider determinants of health | 4. Greater clarity of roles in the system could help develop better collaboration between commissioners and providers. The CCG would have to develop a greater collaboration with social care providers than it currently has | 3. The different skills within health and social care commissioning would be brought together in the CCG under this option however there would be less of a critical mass of commissioners and therefore less opportunity to learn from a wider breadth of skills. | This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture. | 11 |

| Ability of the model to: | Provide one strong and robust strategic commissioning and contract management function | Create an environment of collaboration between commissioners & providers | Develop excellent commissioning skills & expertise across the system | Requires organisational reform (Not Scored) | |
|---|---|---|---|---|---|
| **Option 4 - LA as the lead commissioner model** | 5. This option could provide a strong clear commissioning function. Both people and place based commissioning could be aligned offering considerable benefits to social influences on health. This option has the additional benefit of integrating different skills, experience and knowledge of commissioning. | 4. Greater clarity of roles in the system could help develop better collaboration between commissioners and providers. The LA would have to develop a closer working relationship with health providers than it currently has. | 4. The skills within health and social care commissioning would be used to better effect. This option also offers input from skills and experience of different forms place of commissioning | This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture. | 13 |
| **Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people** | 3. This option maintains a split in the commissioning and contract management functions, just split in a different way than it currently is. | 3. This option goes no further in creating an environment of collaboration between commissioners and providers it is just split in a different way than it currently is. | 3. This option does not make best use of the complete set of commissioning skills across the system, it maintains silos, just different silos that we currently have | This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture. It also relies heavily on significant delegation of responsibilities | 9 |
| **Option 6 – A new Vehicle** | 4. Lines of responsibility are shared providing less clarity than some of the other options. This option will require significant restricting of the commissioning function in order to achieve benefit. | 4. As this option requires the integration of commissioning officers, it does provide an opportunity to join up some strategic and operational commissioning support as well as some back office functions which could lead to greater collaboration | 5. This option could help develop commissioning skills depending on the integration of the officer base that would also be required. | This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture. | 13 |

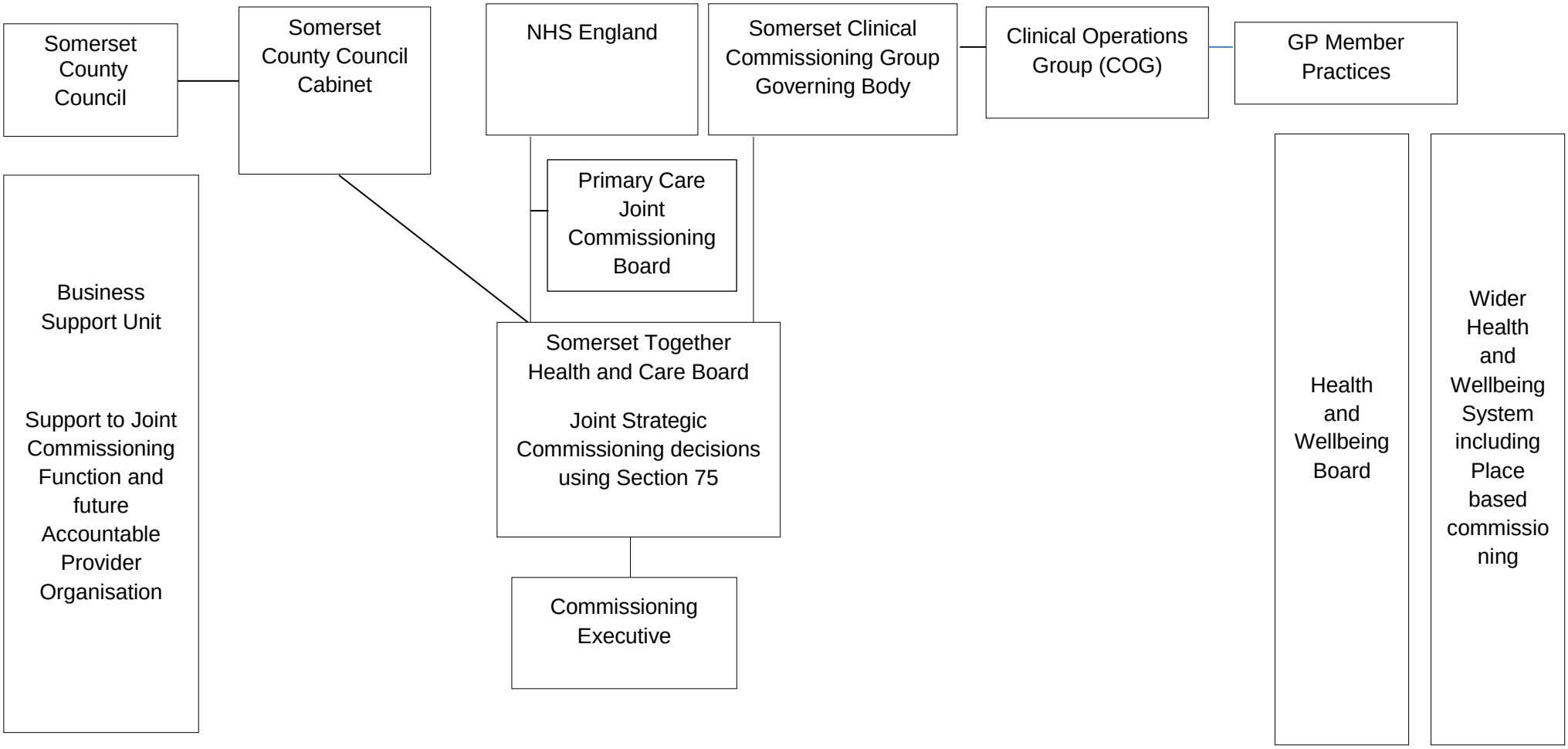
## Financial Considerations

| Ability of the model to: | Make best use of the Somerset £ | Achieve management efficiencies | Make best use of VAT regulations | |
|---|---|---|---|---|
| **Option 1 – Do nothing option** | 2. Likely to deteriorate as less likely to invest jointly in prevention therefore the system will become increasingly less sustainable | 3. Unlikely to achieve management efficiencies | 3. No different than current arrangements | 8 |
| **Option 2- Build on existing funding alignment arrangements** | 5. There would be significant benefits in bringing together these significant streams of public funding and commissioning as one entity, thereby avoiding duplication and cost shunting. The strength of a single vision could bring far greater focus to commissioning for the needs of the population now and in the future. Commissioning across the population and with a capitated budget will incentivise increased investment in preventative work, thereby bringing about greater efficiency in the longer term. | 3. This option simply enables greater pooling of the funding and aligned commissioning priorities, it does not include a joint officer structure and therefore is unlikely to achieve significant management efficiencies | 4. There could be VAT benefits if the pooled arrangements were le4d by SCC | 12 |
| **Option 3 – CCG as lead Commissioner Model** | 4. This option could provide some marginal benefits in the use of the Somerset pound but it depends on the degree to which delegated authority is passed. | 4. Could be some efficiencies through shared roles however this is likely to be restricted if the co-location is at Wynford House | 2. This option is likely to be disadvantageous due to the different VAT treatment in the NHS and LA | 10 |

| Ability of the model to: | Make best use of the Somerset £ | Achieve management efficiencies | Make best use of VAT regulations | |
|---|---|---|---|---|
| **Option 4 - LA as the lead commissioner model** | 4. This outcome could be improved if the LA were the lead commissioner due to less duplication and greater efficiencies. This could be further enhanced if the LA was the lead commissioner as there would be a greater potential for joint investment in some of the wider social and environmental influences on health | 4. Could be some efficiencies through shared staffing, estates etc.. This could be more substantial than option 3 if the co-location was County Hall as there could be greater use of a wider range of support staff | 4. This option is likely to be advantageous due to the different VAT treatment in the NHS and LA | 12 |
| **Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people** | 3. This option simply cuts the commissioning in a different way than it currently does, it is not envisaged that it would make significant difference to maximising the use of the Somerset £ | 3. As this option maintains a split between organisations it is unlikely that this option would make significant efficiencies in management costs | 3. It is unlikely there is significant difference than current arrangements | 9 |
| **Option 6 – A new vehicle** | 5. This option enables efficiencies to be made through integration of the commissioning function and by having the potential to align other budgets and commissioning to gain the greatest health and wellbeing benefit | 5. This option has the ability to achieve savings in overheads and staffing by reducing duplication, estate and travel and enhancing shared back office functions | 4. This option is likely to be advantageous due to the different VAT treatment in the NHS and LA if the LA becomes the accountable body for the entity | 14 |

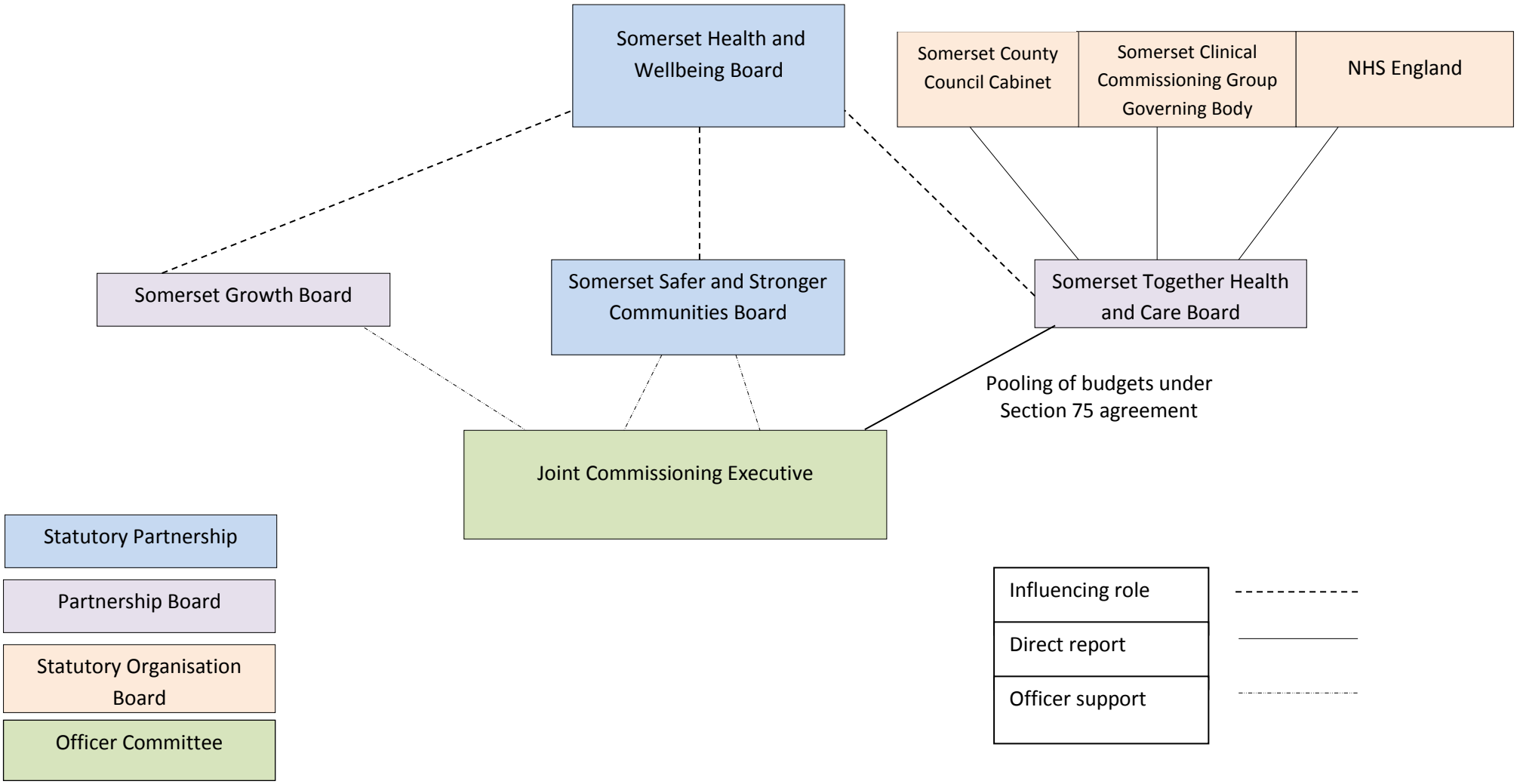
**Appendix 3**

# Proposed Joint Commissioning Governance for the Somerset Accountable Care System



**Appendix 4**

# Potential Countywide Strategic Partnership Structures



**OFFICE SUPPORT (DRAFT)**

**Appendix 5**

HEALTH & WELLBEING BOARD
(Setting strategic direction for Health and Wellbeing)

SOMERSET COUNTY COUNCIL
(Retaining statutory social care and public health responsibilities – set budget and monitor performance and outcomes)

SOMERSET TOGETHER HEALTH & CARE BOARD
(Jointly commissioning health and social care and public health)

SOMERSET CLINICAL COMMISSIONING GROUP
(Retaining statutory health responsibilities – set budget and monitor performance and outcomes)

JOINT COMMISSIONING FUNCTIONS

- Longer term strategic planning and oversight
- Commission in line with the JSNA and HWB Strategy
- Strategic influence across wider health and wellbeing system and across boundaries
- Defining the outcomes and development of Outcomes Framework
- Leadership of the STP
- Contracts and commercialisation
- Assurance and contract management
- Management of strategic risks
- Achievement of financial balance and sustainability
- Ensuring focus on continuous improvement
- Ensuring compliance with policy & regulatory frameworks
- Some continued tactical commissioning

SOMERSET TOGETHER EXECUTIVE LEADERSHIP TEAM

Specific structure of this team to be developed in Phase 2

**PUBLIC, PATIENT AND SERVICE USER INVOLVEMENT, ENGAGEMENT AND PARTICIPATION**

JOINT COMMISSIONER BUSINESS SUPPORT FUNCTIONS -

- Finance
- Corporate governance
- Shared HR / OD function
- Shared legal advice of commissioning functions
- Shared procurement
- Quality and safety function
- IM&T

WHOLE SYSTEM BUSINESS SUPPORT FUNCTIONS -

- Shared business intelligence
- Estates
- Communications

**Appendix 6**

# Joint Commissioning Functions – Initial Thoughts

* A significant part of this activity will be undertaken jointly. Contracting responsibility could sit with an APO in the future under a system where budgets have been delegated. The strategic commissioner will have a contractor role to contract with the APO

| **DRAFT COMMISSIONING REFORM AND GOVERNANCE (subject to agreement with STP)** | | |
|---|---|---|
| | Strategic Commissioning | Accountable Provider Organisation |
| Primary Care | X | |
| Enhanced Services | | X |
| Human Resources and OD | X* | X* |
| IM&T Primary Care | | X |
| Mental Health and LD | X | X |
| Community Contracts | | X |
| Service Improvement/ Development | | X |
| Somerset clinical networks | | X |
| GP Service Leads | | X |
| Strategy | X | |
| Service Development | | X |
| OBC contract & outcomes | X | |
| Governance including FOI & Information Governance | X | X |
| Emergency Planning | X | X |
| Contracting | X | X |
| IT programmes – Sider | | X |
| Discharge to assess | | X |
| Continuing Healthcare | X | X |
| Residential and Nursing homes provision | X | X |
| Homecare including reablement homecare | X | X |
| Community Development & Wider Determinants of Health | X | X |
| Personalisation support services | | X |
| Joint Equipment Service | X | X |
| Information and Demand Management approaches (e.g. Somerset Direct) | X | X |
| Public Health commissioned Services | X | X |

| **DRAFT QUALITY & PATIENT SAFETY (subject to agreement with STP)** | | |
|---|---|---|
| | Strategic Commissioning | Accountable Provider Organisation |
| Medicines management | | X |
| Individual Funding Reviews | | X |
| Safeguarding | X* | X* |
| Quality | X* | X* |
| PALS | X* | X* |
| Continuing Health Care | | X |
| Engagement & consultation | X | |
| Patient Safety | X* | X* |
| Equality Delivery System | X | |
| Infection control | | X |
| Risk management | X* | X* |
| Communications/ engagement | X* | X* |

| DRAFT FINANCE & PERFORMANCE (subject to agreement with STP) | | |
|---|---|---|
| | Strategic Commissioning | Accountable Provider Organisation |
| Financial accounting | X | |
| Management accounting | X* | X* |
| Urgent Care Programme Management | | X |
| Urgent Care Commissioning | | X |
| Performance | X* | X* |
| Acute Service Transformation | | X |

**Appendix 7**

## 14 STP Principles

These *MUST DO* principles should be formally adopted through Boards and communicated throughout the system.

1. We will apply all of our collective resources to deliver outcomes that show we are improving the health and wellbeing for patients, carers and families in Somerset and ensure that we live within the funds available across the system. This is the core principle which underpins each of these subsequent principles.

2. All organisations and individuals **must** commit to system working and act as one: with common purpose, standards and outcomes

3. Leaders **must** test and shadow how an ACS collaboration across Somerset would work.

4. Boards **must** align their organisations' day to day operations, executive responsibilities and management support to deliver system wide immediate recovery and radical transformations.

5. For the first phase of delivery of the STP, there **must** be immediate and persistent focus on the three keys to system recovery: cost reduction, demand reduction and return on investment (ROI)

6. There **must** be a System Financial Framework that is Outcome Based, supports an affordable STP and is underpinned by business processes that will deliver the change. Including Minimum Income Guarantees, incentive payments and risk share.

7. There **must** be a single system savings plan with organisational components. Ongoing and committed individual organisation CIPs/Recovery Plans they must transparent across the system.

8. Long Term Financial Models **must** be updated regularly to reflect the long term vision of the STP and progress towards it.

9. There **must** be a common set of measurable quality, outcome and financial targets, commonly agreed, understood and articulated by all.

10. All proposals **must** have a system impact assessment and actions evidence the impact being made

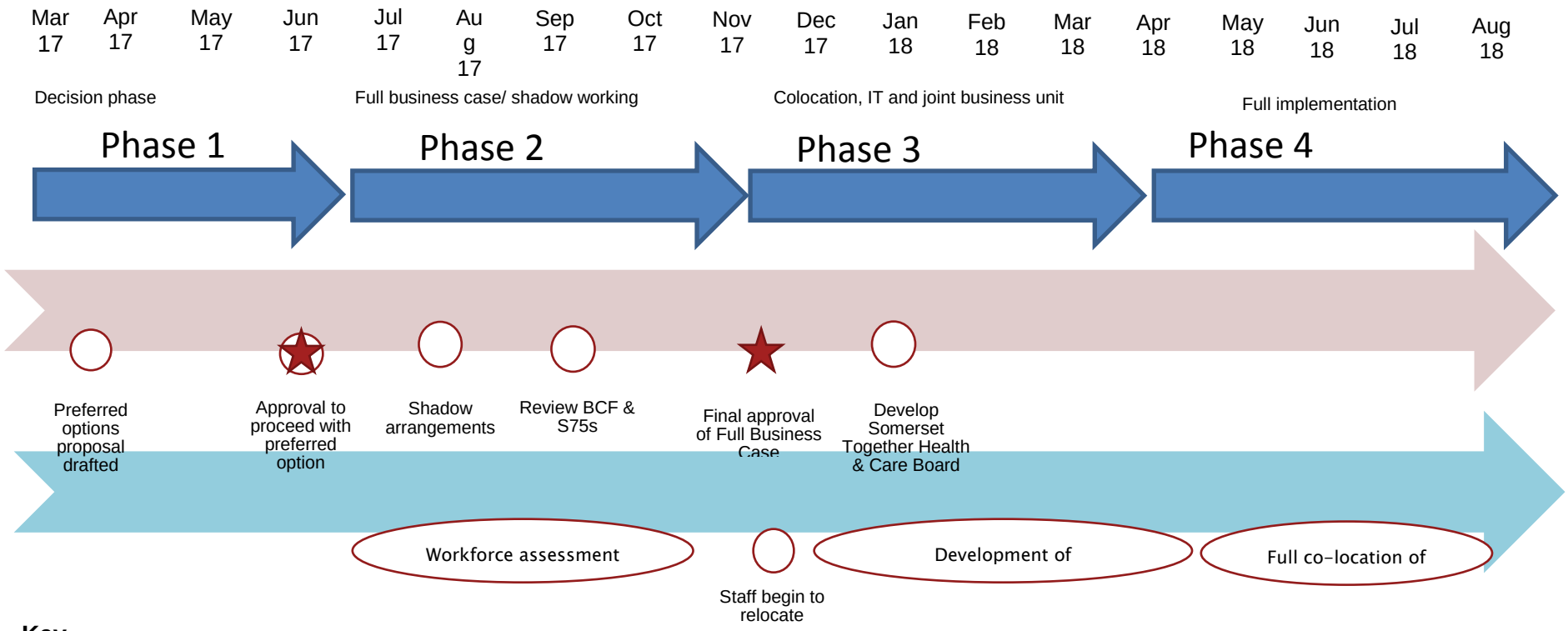
11. All agreed plans **must** have identified system leader responsibility and dedicated operational support (PM and PMO

12. All OD, personal development and recruitment and retention **must** be developed and delivered within an ACS framework.

13. There **must** be agreed common messages and shared responsibility across all organisations to communicating, involving and engaging patients, carers, staff, public and other stakeholders.

14. All system leaders **must** be held and hold each other and their teams to account for delivery, based on system level evidence.

# Indicative Timeline for Joint Strategic Commissioning Function




**Key**

★ Approval required by Governing Body and Cabinet

○ Key actions