Herefordshire Council

AGENDA

Health and Wellbeing Board

Date: **Tuesday 18 September 2012**

Time: **3.00 pm**

Place: **Council Chamber - Brockington**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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If you would like help to understand this document, or would like it in another format or language, please call Tim Brown, Governance Services on 01432 260239 or e-mail tbrown@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairman	**Councillor PM Morgan**

Jacqui Bremner	Local Involvement Network
Peter Brown	Herefordshire Business Board
Chris Bull	Chief Executive Herefordshire Public Services
Shaun Clee	Chief Executive - ^{2}gether NHS Foundation Trust
Jo Davidson	Director for People's Services
Supt Charles Hill	West Mercia Police
Claire Keetch	Third Sector Board
Jo Newton	Chairman NHS Herefordshire (PCT) Board
Howard Oddy	Acting Chief Executive–Wye Valley NHS Trust
Elizabeth Shassere	Director of Public Health
Dr Andy Watts	Chair - Clinical Commissioning Group

AGENDA

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- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.
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HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health and Wellbeing Board held at Council Chamber - Brockington on Tuesday 19 June 2012 at 3.00 pm

Present: **Councillor PM Morgan (Chairman)**

Dr S Aitken, Ms J Bremner, Mr P Brown, Mrs J Davidson, Mr S Ghazawy, Mrs C Keetch, Mr H Oddy and Mr D Taylor

In attendance: **Councillors JLV Kenyon and Mr L Griffin.**

Officers: **R Beavan-Pearson (Assistant Director –Customer Services and Communications), M Spinks (Principal Research Officer), Dr A Talbot-Smith (Consultant in Public Health Medicine), C Wichbold MBE (Grants and Partnership Officer) and T Brown (Governance Services).**

1. APOLOGIES FOR ABSENCE

Apologies were received from Mr C Bull, Supt C Hill, Dr A Watts and Mr M Woodford. Apologies were also received from Councillor JG Jarvis.

2. NAMED SUBSTITUTES

Dr S Ghazawy substituted for Dr A Watts, Mr H Oddy for Mr M Woodford and Mr D Taylor for Mr C Bull.

3. DECLARATIONS OF INTEREST

There were none.

4. MINUTES

RESOLVED: That the Minutes of the meeting held on 20 March 2012 be confirmed a as a correct record and signed by the Chairman.

5. UNDERSTANDING HEREFORDSHIRE - THE 2012 INTEGRATED NEEDS ASSESSMENT

The Board considered the 2012 summary Integrated Needs Assessment (INA) and the programme of work towards a “Gold Standard” Integrated Needs Assessment.

The Consultant in Public Health Medicine presented the report. She highlighted that the document was integral to the commissioning cycle, providing an explicit evidence base that would enable strategic priorities, commissioning decisions and partnership working to be based upon a clear and comprehensive understanding of need. She specifically invited comment on areas where the Board would like more in depth analysis over the coming year.

The Principal Research Officer gave a demonstration of how the information underpinning the high level summary document was made available on the Council’s website.

In discussion the following principal points were made:

- The asset base as a whole required further analysis. Carers were highlighted as a vital asset that needed to be protected. More analysis was needed on the needs of carers including their access to healthcare services.

- It was suggested that there also needed to be more analysis of mental health and wellbeing needs.

- Changes to the welfare system and growing poverty were highlighted as issues that would have an impact on the County.

- The potential for facilitating self-help needed further consideration.

- The locality analysis was welcomed and its potential benefit to all providers acknowledged. It was emphasised that it was important that the analysis was considered in localities and the differences between localities and the need and scope for action to address these differences discussed.

- The importance of ensuring that the Board's priorities were firmly founded on the evidence and that the analysis was used to inform considerations across all organisations in the County was emphasised. When matters came before the Board for consideration evidence should be provided to demonstrate how proposals addressed the issues highlighted in the INA.

- On behalf of the Clinical Commissioning Group (CCG) it was suggested that the scheduled bi-monthly meetings of practitioners could provide a useful forum for ensuring the analysis was more widely shared.

- The potential to develop the website to make it interactive, generating user feedback and information on people's experience of services was noted.

- It would be of benefit to demonstrate in the INA summary how account had been taken of information gathered at stakeholder events.

- A view was expressed on behalf of the CCG that whilst the INA was a vital part of the evidence base there were additional sources of information of which the CCG needed to take account in forming the commissioning strategy. This included directives from the Department of Health, and qualitative issues including information gathered directly by clinicians and other frontline staff. There may therefore be instances where the priorities agreed by the CCG did not correspond precisely with those in the INA.

  The consensus was that it was important that the INA captured all the available sources of information and organisations highlighted any aspects of which account had not been taken. The engagement process was designed to achieve this objective. It was recognised that having considered the available evidence organisations might reach different conclusions about priorities. However, the Board had a responsibility to assess the extent to which strategic priorities and commissioning decisions to invest or disinvest were linked to the evidence base provided by the INA.

- It was proposed that a further report be submitted to the Board in July 2012 on the rolling programme to develop the INA, taking account of issues raised during the discussion.

RESOLVED:

That (a) the document "Understanding Herefordshire" appended to the report be approved as the summary of the 2012 Integrated Needs Assessment and it be recommended that its findings be embedded and used across all organisations in the County;

(b) "Understanding Herefordshire" and the 2012 Integrated Needs Assessment be approved as the evidence base against which strategic priorities and commissioning decisions to invest or disinvest will be made and assessed in an open and transparent way; and

(c) the following areas be proposed for more in depth analysis over the coming year: the asset base, the needs of carers; and mental health and wellbeing needs; and

(d) **a further report be submitted to the Board in July 2012 on the rolling programme to develop the Integrated Needs Assessment including enhanced analysis, capturing the additional sources of information and proposing the prioritisation of the areas of more in-depth analysis during 2012/13.**

6. HEALTH WATCH HEREFORDSHIRE

The Board considered the progress made to date regarding Healthwatch Herefordshire.

The Assistant Director – Customer Services and Communications presented the report and the appended discussion paper. Four options were set out in the discussion paper. The Board was invited to support Option 2 – providing the Healthwatch function as part of an existing not for profit organisation.

In discussion the following principal points were made:

- The consultation undertaken on the options to date was discussed. It was noted that this was ongoing. Cabinet was due to consider the proposal on 12 July 2012 and, given the tight timescale it was advised that responses would be accepted until the day before that meeting.

- The Board sought clarification on the approach across the region and was informed that a range of options were being explored. It noted that if it were to be pursued the detail of option 2 would need to be developed. Whether any local organisation would be a suitable provider would need to be established at that point.

- It was emphasised that a number of lessons needed to be learned from the operation of the Local Involvement Network, the predecessor to Healthwatch. In establishing the new function there were a number of reputational issues to consider. It was essential that the function demonstrated independence and was capable of delivering effective challenge to commissioners and providers.

- The Board acknowledged the tight timescale for putting arrangements in place and supported option 2, but on the basis that this would be for a two year period with a view to exploring procurement options after that time.

RESOLVED:

That (a) the content of the discussion paper be noted; and

(b) the recommendation to pursue option 2 – that Herefordshire Healthwatch be provided through an arrangement with the local voluntary sector be supported, on the basis that this was for a two year period with a view to exploring procurement options after that time.

7. HEALTH AND WELLBEING COMMUNICATIONS AND ENGAGEMENT STRATEGY AND PARTNERSHIP WORKING

The Assistant Director – Customer Services and Communications presented the report.

The Board discussed a number of recent communication and community engagement issues that had arisen. The Assistant Director confirmed that lessons had been learned from these episodes and the strategy was designed to address them.

The Board proposed that a further report should be made on how the Strategy was being implemented and an informal sub-group be formed to provide a sounding board.

RESOLVED:

That (a) the report be noted and the Board continue to support the implementation and development of the joint communications and engagement strategy, as appended to the report;

(b) the further local integration of communications and engagement working be supported in line with the model set out at page 88 of the agenda papers; and

(c) a further report be made to the Board on how the Strategy is being implemented; and

(d) an informal sub-Group of Board Members be formed to provide a sounding board for the development and implementation of the Strategy.

8. HEALTH AND WELLBEING BOARD WORK PLAN

The Board noted the Work Plan.

The Chairman outlined the intention to hold some meetings at external venues incorporating visits to service providers and to undertake other activities through which the Board and its Members could raise the Board's profile.

9. WORKSHOP UPDATE

The Chairman reported that work to take account of the outcomes of the last workshop had been completed and a draft paper would be circulated.

10. FUTURE MEETINGS

The Board noted the list of scheduled meetings.

The meeting ended at 5.03 pm **CHAIRMAN**

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 SEPTEMBER 2012**
TITLE OF REPORT:	**PRIORITIES REPORT FROM THE HEALTH AND WELLBEING STRATEGY TASK AND FINISH GROUP**

CLASSIFICATION: /Open

Wards Affected

County-wide

Purpose

To report on the work undertaken on behalf of the Health and Wellbeing Board by the Task and Finish Group on the approach taken to the priorities submitted by Board members which will contribute to the emerging Health and Wellbeing Strategy.

Recommendations

THAT:

(a) the Health and Wellbeing Board agree the approach to the priorities submitted by Board members taken by the task and finish group to progress the Health and Wellbeing Strategy; and

(b) the Health and Wellbeing Board agree to the Health and Wellbeing Strategy priorities being clustered into three main areas: sustainability of the health and social care system, demand management and crisis prevention.

Key Points Summary

- The Health and Wellbeing Board (the Board) had previously identified its core purpose as being the strategic leadership of the health and social care system, with partnership working as the key for solving the issues in the system. The Board has agreed a vision and guiding principles for the emerging Health and Wellbeing Strategy (the Strategy).

- At its last meeting on 10 July the Board agreed to review the priorities for the emerging Strategy previously presented in February 2012 in the light of the Understanding Herefordshire 2012 report.

- Board members were asked to submit a list of their organisation's priorities for consideration in relation to the areas of need presented in Understanding Herefordshire. A task and finish group of Board members was set up to work through the priorities. The group met and discussed the priorities and identified and agreed a grouping of priorities where duplication and similarities occurred.

Further information on the subject of this report is available from
Elizabeth Shassere, Director of Public Health on (01432) 260668 (PA)

- The group reviewed and clustered the combined list of priorities into three groups: sustainability of the health and social care system; demand management; and crisis prevention.

- Further discussions led to the group identifying sustainability of the system as the key priority upon which all others potentially depend, and therefore should be main initial focus of the Board and its strategy. The group also identified issues such as joined up commissioning and better pathways as a second group of priorities, and a third group around immediate and necessary activity for family support.

- It was also acknowledged that these priorities need to be considered in the light of other similar processes being undertaken by partner organisations such as the Herefordshire Partnership Executive Group (HPEG) as there may be overlap in terms of delivery.

- There is also scope to consider the role of the future of Health Scrutiny in complementing the Board's primary priority of a sustainable system, particularly the focus on the effectiveness of the system.

- The membership of the task and finish group which undertook this work is Councillor PM Morgan, Dr Sarah Aitken, Jacqui Bremner, Dean Taylor, Dr Andy Watts and Clare Wichbold, with Elizabeth Shassere from 1 August 2012.

- Board members have made an initial assessment of their organisation's priorities against the set of prioritisation criteria proposed at the last meeting of the Board. The collective priorities were further grouped within each category as follows:

Sustainability of the health and social care system	**Organisations with identified priority**	**Lead organisation (tbc)**
HWBB would provide the strategic overview, direction, and accountability for the success of this objective and be the focal point for concerns about the effectiveness of the system		
Financial sustainability of the health and social care system in Herefordshire	CCG, HC People's Services, HC Political Leadership, NCB/PCT Cluster, Wye Valley Trust	
Focus on effectiveness of system	LINK, NCB/PCT cluster, HC People's Services, HC all directorates	
Demand management	**Organisations with identified priority**	**Lead organisation (tbc)**
There will be many areas where the work is already taking place, such as in HPEG, or the Community Safety Partnership, or through public health strategies		
Fuel poverty	3rd Sector, HHL	
Alcohol consumption	Public Health, WMPA, HC People's Services	
Coordination of care	LINK, WVT	
Support older people to live in their own homes	Public Health, CCG, NCB/PCT Cluster, HHL, WVT, 3rd Sector, HC People's	

	Services	
Improve joined-up care pathways	PH, WVT, CCG, HC People's Services, NCB/PCT Cluster, HCS	
Health and wellbeing of carers	Public health, HCS,	
Self management and self responsibility	Link, Public Health, WMPA, HC People's Services, NCB/PCT Cluster	
Improve understanding of mental wellbeing	HC People's Services, Public Health	
Crisis prevention	**Organisations with identified priority**	**Lead organisation (tbc)**
To address these areas requires a system-wide approach to ensuring pathways are person-centred and reduce duplication while not letting anyone fall through the gaps		
Target interventions to most vulnerable groups	3rd Sector, HHL, HC political leadership, HC People's Services, NCB/PCT cluster	
Prevention of family crisis	WMPA, Link, CCG, NCB/PCT Cluster, HC People's Services	
Health and wellbeing of children	NCB/PCT Cluster, 3rd Sector, HHL, HC People's Services, Public Health	

- The deliverables related to the priorities will be taking place in other forums with potentially different leads and partners, as well as those on the HWBB. One example of this is the development of the Clinical Strategy in relation to the **sustainability** priority grouping. This is being led by the CCG as tasked by the SHA to reconfigure the clinical footprint so that it is sustainable and sensible for our population and geography, and to support the clinical providers through difficult times so that standards of patient care are maintained and improved and financial balance can be addressed. This is one very important element that will take the community forward toward having a sustainable health and social care system. The HWBB would receive and consider the strategy and any recommendations and take a view on it. Members would provide a strategic, high level view and any support to barriers and any direction through specific challenges faced as appropriate.

- Clearly there will be other pieces of work that support this strand, such as some of the root and branch reviews of social care services, that would also help achieve this strategic goal. The HWBB could take a view on how an approach to ensuring sustainable social care services that might be led, for instance, similar to the Clinical Strategy.

- The HWBB members would be best placed to debate solutions offered and to help find ways through problems and challenges for all the priority groupings. Representative partners could also bring gaps in effectiveness of the system to the board for assistance in addressing those. For instance, if GPs through the CCG identified a key provider or partner that was causing a breakdown in a pathway or service, this concern could be brought for discussion into the HWBB, where perspectives on a solution could be gained, such as perhaps a collective contribution to a resource if needed, or perhaps a more assertive approach might be needed if a partner is not acting collaboratively or is operating in a risky manner.

- For **demand management** priorities, for example, it would not be for the HWBB to operationalise the delivery of a strategy and action plan on reducing alcohol consumption, but know where the current alcohol strategy sits and who is taking a lead.

- The Board would put the priorities under this strand on a rolling programme to review progress against them, by asking the lead representative to bring these into the HWBB where again support and solutions could be offered when relevant as well as offering challenge and a level of governance and accountability.

- Finally, for **crisis prevention**, these are clearly very complex and inter-related areas that no one service or organisation can tackle or take forward alone. Much of this work may be addressed by some of the root and branch workstreams, or for instance in existing forums such as in the Women and Children's Commissioning Group or Early Years Forum.

- All three areas would be served by tasking key contributors with mapping the work taking place underneath them, so that it can be joined up and made most effective. The HWBB can then review this and learn how best to provide that strategic overview and understand what needs to be taken forward to achieve the main objectives as set out.

How will your report meet the vision and guiding principles of the HWBB?

The priorities will form a key part of the emerging Strategy which will set out how the Board intend to deliver the vision and guiding principles.

Reasons for Recommendations

The Health and Social Care Act 2012 requires Health and Wellbeing Boards to agree a Health and Wellbeing Strategy.

Introduction and Background

The Health and Social Care Act 2012 (the Act) requires the formation of Health and Wellbeing Boards which become statutory on 1 April 2013. Enshrined in the Act is the requirement for Health and Wellbeing Boards to agree a Health and Wellbeing Strategy. The Act brings into being Clinical Commissioning Groups with effect from 1 April 2013 subject to a formal authorisation process. The Act contains a number of duties which require that the Clinical Commissioning Group is engaged with the local emerging Health and Wellbeing Strategy to enable alignment of commissioning plans. The Act will abolish Primary Care Trusts on 31 March 2013.

Key Considerations

The emerging Strategy will be the key strategic document for the Board. It will have an impact on the health and wellbeing outcomes for the county's population. The Strategy will link to other key strategies for Herefordshire.

Community Impact

The Strategy will involve a range of key partners and partnerships to deliver the Strategy.

Equality and Human Rights

The Strategy pay regard to the Public Sector's duty with regard to equality and diversity by identifying priority groups for support, and the means by which services will be provided and

measures of success.

Financial Implications

The Health Wellbeing Strategy's priorities will influence future allocation of funding and resources.

Legal Implications

The general duties and powers relating to Health and Wellbeing Boards under the Health and Social Care Act 2012 which comes into effect on 1 April 2013 include the preparation of a joint Health and Wellbeing Strategy.

Risk Management

a. What are the risks to the Health and Wellbeing Board if the proposals in the report are agreed; and how do you intend to manage these risks? None

b. What are the risks to the Health and Wellbeing Board if the proposals in the report are declined; and how do you intend to manage these risks?

Failure to progress the development of the emerging Strategy may jeopardise the formal authorisation of the Herefordshire CCG prior to the abolition of Herefordshire Primary Care Trust on 31 March 2013

Failure to progress the development of the emerging Strategy may delay the development of the Health and Wellbeing Board's readiness to take on the system leadership function for Health and Wellbeing in Herefordshire.

Consultees

The emerging Health and Wellbeing Strategy is being informally consulted on as it is being developed through the Board. There are no proposals for a formal consultation process.

Appendices

None

Background Papers

Priority Group 1: Sustainability of Health and Social Care System in Herefordshire

Priority Group 2: Demand Management

Priority Group 3: Crisis Prevention

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 SEPTEMBER 2012**
TITLE OF REPORT:	**DEVELOPING A CLINICAL COMMISSIONING STRATEGY**

Wards Affected

County-wide

Purpose

The purpose of this report is:

- To update the Board on the development of, and rationale behind Herefordshire's Clinical Commissioning strategy
- To engage and consult on the current version of the strategy
- To outline how this work is contributing to the development of the Clinical Commissioning Group's (CCGs) commissioning intentions for 2013/14
- To describe how this strategy and associate plans link and will contribute to the delivery of the Health and Wellbeing boards priorities and principles

Recommendation(s)

THAT the Board:

(a) endorses the principle and rationale behind the Clinical Strategy;

(b) engages and contributes to the development of the strategy and further iterations are presented and discussed at future HWBB sessions; and

(c) notes the timetable and process for development and agreement of the CCGs Commissioning intentions,

Key Points Summary

- With the deteriorating position of Wye Valley Trust financially Herefordshire Clinical Commissioning Group with Wye Valley Trust clinicians and Herefordshire Council have been rethinking the clinical strategies that need to be employed over the next five years to ensure that the challenges identified within the Integrated Needs Assessment are systematically dealt with.

- Midlands and East SHA have also requested that the CCG lead the development of a clinically lead commissioning strategy for Herefordshire that focuses on transformation change in the County. The SHA have asked for a narrative concerning the strategy and its development to be provided by early September.

- To this end an initial draft strategy document has been produced [attached] that outlines the challenges faced by Herefordshire and the processes that will be followed to move this work forward. The strategy notes Herefordshire faces a number of specific health challenges related to a largely rural, sparsely populated geography and a relatively underdeveloped provider market. Transforming the Herefordshire Local Health Economy to put the patient and the public at the centre will therefore depend on realising efficiencies and providing better quality of care.

- Resilient partnership working and sustainable clinical networks will be crucial in achieving the vision and strategic objectives; these have been informed by both local health needs analysis provided by the JSNA and national, regional and local priorities. It describes the need to consider different service delivery and configuration models, as well an importance of focusing on care pathways to ensure transformational change. Consideration around financial incentives frameworks and skills mix across the pathways will also be part of the strategy.

- Support is being sought from Professor Sir Muir Gray (NHS Chief Knowledge Officer Department of Health) and Map of Medicine to move this work forward; Herefordshire's Clinical Strategy Group will be the key group tasked with driving the plan and strategy onwards. This group next meets on the 11th September *[feedback from this group will be given to the HWBB on 18th September]*. Details of how the development of the strategy will be implemented and governed are also included in the attached document.

- Work on the strategy and plan will be taking place over the next 6 months, in preparation for full implementation in 13/14. Robust planning, based on a strong evidence base, subsequently supported by a strong programme and governance model will be essential to ensuring the plan is implemented successfully.

- The Clinical Commissioning Strategy will inform and guide the CCGs Commissioning intentions for 13/14. In essence though the central tenants of these will be the continued development of neighbourhood teams, continued move away from a bed based model of care, revisiting the role of Community Hospitals and with a core focus on care and clinical pathways.

How will your report meet the vision and guiding principles of the HWBB?

- The Clinical Commissioning Strategy's primary aim is to deliver transformational system change for benefit of Herefordshire's patients and public in an ever challenging financial climate, to this end it is designed to support the delivery of the HWBB vision, as well as aligning to national and regional priorities.

- The CCG will be key in commissioning services aimed to deliver improved outcomes for Herefordshire residents and in particular, the HWBB overall outcome of reducing the difference in healthy life expectancy in Herefordshire. The CCG continued work around the care pathways will be central to supporting the delivery of the HWBB vision.

- In particular the work being developed for the Clinical Strategy will support the HWBB principles focusing on creating a sustainable unified, affordable, focused system delivering the right service at the right time in the right place. And ensuring the appropriate support will be

provided for people when in hospital to encourage a return to independence wherever possible and when required, long term and end of life care will be dignified and caring.

- The Clinical strategy will also underpin the delivery of the proposed priorities of the Joint health and wellbeing strategy, in particular the

    - sustainability of the health and social care system upon which all others potentially depend,

    - and joined up commissioning and better care pathways

Reasons for Recommendations

- The Health and Wellbeing Board is a primary stakeholder in Herefordshire's Health and Social Care economy; it is responsible for delivering Herefordshire's Joint Health and Wellbeing strategy and it's JSNA *(Understanding Herefordshire*). It will therefore need to assure itself that the local authority and the CCG (with its PCT partners) is commissioning services in line with its vision and principles, and it support the delivery of the HWBB intended vision and principles around resilience, reducing health inequalities and emotional and physical health improvements.

Key Considerations

- The Clinical Commissioning Strategy is a vital component of the health and social planning framework; they will guide and inform commissioning plans and intentions over the next 12 months and beyond, and will support Clinical commissioners in their work over the coming 5 years. HWBB members need to assure themselves that the plans support and align to its priorities and will assist in responding to the JSNA recommendations.

Community Impact

- Engagement events with Clinicians, residents over the last year have feed into the development of the strategy and will continue to do. The HCCG plan will need to support and align to the Joint Health and Wellbeing strategy, going forward to ensure it supports the delivery of improved health outcomes. One of the CCGs central values is putting '*patients and residents at the heart of everything it does'*; key to this will be robust community engagement over the coming years, as it develops future plans.

Equality and Human Rights

- The CCG operational plan outlines the HHCC's commitment to equality, diversity and human rights it states, it will;

    - Ensure PSED and consideration of vulnerable groups is embedded within our Commissioning cycle;

    - Work locally with other Hereford Public Services as a member of Equality and Diversity Forum;

    - Embed it as a key element of its governance processes and values;

    - Ensure that all providers comply with PSED and that it forms part of contract schedules; and

    - Make certain that Quality and Equality Impact Assessments are undertaken on

QIPP schemes and programmes

Financial Implications

- The plans outline the significant challenges faced by the Health and Social Care System as a whole.

Consultees

Herefordshire Clinical Strategy Group

WVT Trust Board

PCT Cluster

Hereford Council Directors

CCG Board

Background Papers

- CCG Operational Plan 12/13;
- West Mercia PCT Cluster Integrated system plan; and
- NHS Operating Framework.

Document Control
Document Location
This document is only valid on the day it was printed.
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Revision History
Date of this revision: 31/08/2012
Date of Next revision:

Version	Date	Author/Editor	Change Description
V0.1	24/08/2012	CG	Initial early draft
V0.2	25/08/2012	ME	Governance piece added
VO.3	29/08/2012	CG	Clinical strategy additions following contract meeting
VO.4	30/08/2012	LH	Re-formatting
V0.5	31/08/12	NB	Final first draft to Board

DRAFT Clinical Commissioning Strategy

for

Herefordshire CCG

HEREFORDSHIRE
Clinical Commissioning Group

NHS
Herefordshire

Contents:

1. Introduction

Herefordshire Clinical Commissioning Group aims to achieve a high quality, sustainable and pathway driven health economy with the patient and public at the heart of everything we do. However, Herefordshire CCG faces a number of specific health challenges related to a largely rural, sparsely populated geography with an underdeveloped provider market. Transforming the health economy to put the patient and public at the centre will therefore depend on realising efficiencies and demonstrating effectiveness of clinical care by using integrated pathways. Partnership working, with the Council and all our other partner organisations will also be key to the transformation as we will want to ensure that our providers work within sustainable clinical networks so that the people of Herefordshire are receiving the highest quality and safety of care.

2. Financial Context

The CCG faces a challenging financial position and the projections going forward to 2015 show that the money available to the health economy is:

Recurrent Budget Allocations 2012/13 to 2017/18 :

	£	
2012 / 13 Budget	2,10,111,593	Recurrent Budget as at Month 04
1% Insurance Risk Reserve	2,101,116	
Uplift at 2.51%	5,326,539	
	217,539,248	**2013 / 14 Recurrent Budget**
Uplift at 2.40%	**222,760,190**	**2014 / 15 Recurrent Budget**
Uplift at 2.40%	**228,106,434**	**2015 / 16 Recurrent Budget**
Uplift at 2.40%	**233,580,989**	**2016 / 17 Recurrent Budget**
Uplift at 2.40%	**239,186,933**	**2017 / 18 Recurrent Budget**

Note : Annual uplifts are estimated as detailed in the main text and will be subject to change as allocation details are confirmed and clarified.

In addition, previous estimates of the Herefordshire health economy QIPP target was estimated at £68m until 2015 see table below:

	Cash Releasing Savings				
Years	Efficiency built into provider contracts £000's	PCT action to reduce existing spend £000's	Planned disinvestment in services £000's	Other Savings £000's	Annual Totals £000's
2011/12	9,865	5,465	5,033	375	20,738
2012/13	8,893	5,231	2,611	80	16,815
2013/14	8,944	2,976	2,945	70	14,935
2014/15	8,995	4,168	2,076	70	15,309
Totals	**36,698**	**17,840**	**12,665**	**595**	**67,798**

The scale of the financial challenge we face in the future is great. Every year the CCG will face additional pressure on the funding we receive due to inflation, demographic changes of an ageing and growing population and the cost of innovative new technologies and drug advancements.

The CCG is working on and modelled through a 2.8% increase for 2012/13, for 2013/14 a 2.5% (guidance from NCB), and 2014/15 2.4% (advice from Nuffield Institute of Health Care). As a result of this work one of the objectives for the CCG Board to come into recurring balance the health economy will need to drive high levels of efficiency in the current system, look at new and innovative ways of commissioning providers to provide services and engage all clinicians in the debate about Herefordshire health system.

The CCG is also cognizant that if it is to continue to invest in additional services or new services, these will need to be aligned to the clinically driven priority areas and address the health inequalities prevalent in the population. This will have to be funded through decommissioning services that are not evidenced based or performing at a less than optimum way.

As part of the Clinical Commissioning Strategy the financial strategy has been underpinned by financial models which are being further developed with scenario modelling and risk assessment. The most important issues that have been factored in are set out below:

- **Government Spending Review**

Despite the UK economic downturn, the outcome of the 12/13 Spending Review represents a relatively favourable financial settlement for the NHS. The CCG is planning on a small element of real terms growth from 2012/13 of circa 2% year on year until 2015. . This supports all the information available at the current time and is in line with the PCT Cluster allocations already confirmed for 2012/13.

- **Implications of the QIPP Initiative on the Local Health Economy**

The 2012/13, 14, 15 QIPP initiatives have been modelled into the financial strategy and the clinicians in Herefordshire are aware of the need to deliver the savings. The overall QIPP target from 2011/12 to 2014/15 has previously been communicated as £68m.

- **Current Year Activity Pressures**

In year information on material activity pressures have been reflected in the revised plan, particularly in respect of the acute secondary care, special placements and continuing healthcare pressures.

Taken together these changes will substantially reduce the scope for new investment during the current financial planning period and emphasis is placed on the need to invest only in schemes or activities that will the greatest benefit to the population of Herefordshire using a clinically driven, evidenced based approach. The CCG will look for innovation, local tariffs, changes in national tariffs and service redesign to pump prime service configurations in line with the patients views and expectations of service delivery in Herefordshire. The strategy, therefore, will lead to a reduction in the relative expenditure on hospital based activity, allowing the acute sector services to network with other providers to provide sustainable levels of safe, high quality clinical care and to increase the services of community and primary care based services focusing on the neighbourhood team concept and wrapping services around the patient.

Regular review of investments against criteria used in the investment planning process will be undertaken and will help to inform the disinvestment process.

Scenario planning

Herefordshire CCG has identified through this draft clinical strategy a range of financial scenarios. The three main scenarios can be described as follows:

Base Case (Likely) Scenario

In this scenario the CCG will contract for a realistic level of activity over the life of the three year plan based on past activity performance and forecast future demand. Unallocated resource would be invested in a series of prioritised initiatives, aligned with the Local Authority strategies where appropriate, leading to initiatives focused on improving health outcomes, reducing health inequalities identified through the integrated needs assessment and helping the people of Herefordshire to remain independent in their localities for as long as possible. The CCG would look to invest in primary and community care. Service reconfiguration, to enable this to happen, will need to come from within existing resources of the health economy with little pump priming available.

Best case Scenario

In this scenario the CCG will again contract for a realistic level of activity over the life of the plan but the additional unallocated funding will be used to go further and faster on the transformation agenda of care closer to home and independent living for the population aligned to their localities. It is envisaged that pump priming will be provided by the CCG in order to deliver the strategic priorities and to incentivise providers to further improve quality, innovate and experience for our patients who use their services.

Worst case Scenario

In this scenario the CCG would shift the focus of activities to the management of demand and mitigation of cost increases. The CCG would contract for lower than expected levels of

activity and use all the available levers to manage demand, especially via the contract, on all providers. There would be no ability to fund new ways of working and the CCG would be looking to decommission activity.

The need for change and a clinical commissioning strategy that drives the change to becoming a health economy in balance is now paramount. The current Strategic health authority has also made it clear that they cannot support any non-recurrent funding of the provider going forwards from 2013.

3. Context for change

In 2008 Herefordshire embarked on a major change programme bringing together the health and social care community to look at the organisation and delivery of health and social care. The strategic 'Provider Services Review' was undertaken by Health Services Management Centre in Birmingham University. As part of this review clinical teams came together and there was consensus on the need to develop integrated care pathways delivered by an integrated hospital, community and adult social care organisation. However, the final report did not make this explicit recommendation! It should be noted that the Primary care services provided by GPs choose to stay outside of this proposal.

In 2009 KPMG were commissioned to;

'Assess the viability of Herefordshire Hospital Trust and the PCT Provider arm as standalone organisations; and determine the potential clinical and financial viability of a single integrated healthcare provider '.

As part of the work KPMG flagged to the different organisations that by 2014 the health economy would be in a cumulative deficit of £23 million if no action was taken. The result of the work was that Wye Valley NHS Trust was created in April 2011 providing acute, community and adult social care. This was the first integrated trust in England. However, this trust was predicated on a continued financial investment by PCT/commissioners and it was noted that £2.3m was required for the neighbourhood team development, which was to deliver avoidance of a need for hospital admission, quicker discharge from hospital and reductions in delayed transfers of care. Further resources were predicted to be released by the integration and this projected to be a benefit of £6m per annum. Pathways of care were also identified and it was agreed by the PCT that locally developed tariffs would be developed. Alongside this the Wye Valley NHS Trust were pursuing an application for F/T status.

A review in August 2012 of the Integrated Care Model by Wye Valley NHS Trust Programme Management office has identified that the investment was not made due to the financial pressures across the health economy and the resources being required to fund the over performance of the trust in 2011/12; the model of care did not deliver enough savings to bridge the gap between income and expenditure resulting in increasing cost improvement plans; the proposed locally developed tariffs were not developed or implemented; that organisational integration took precedent over the clinical integration which was integral to the whole change programme. The review also found that commissioning intentions have

been made piecemeal rather than as an overarching strategy to support the transformation of care.

4. Current issues

In May 2012 Wye Valley NHS Trust produced a document 'Case for Change: Financial viability and the Way Forward' to the Midlands and East, West Midlands SHA asking for £9.5m non-recurrent support in 2012/13. Following that meeting the Trust were asked to fully identify the £5.5m of CIPs and the SHA made it conditional on the £9.5m being offered that the CIPs were delivered. In addition, the PCT/CCG was asked to agree and present a narrative identifying 'the future clinical strategy and governance structure to oversee securing a clinically and financially viable sustainable organisational form for the Trust by the start of September.'

This work has now begun.

5. Integrated Needs Assessment

In order to work through a high level clinical strategy it is important to understand the health context of Herefordshire in 2012 and further information can be found in 'Key Findings about Herefordshire Localities' at www.herefordshire.gov.uk/aboutlocalities. Key issues that come from the integrated needs assessment are:

- Herefordshire has a population of 182,800, representing growth of 4% (7,900 people) since 2001; it is predicted to grow by 205,700 by 2013;
- The population already has a relatively old age structure but older people are expected to increase disproportionately to the total population. 6,500 households consist of elderly, socially isolated persons.
- By 2031 the number of people aged 85+ will more than double to 12,700.
- Amongst the Minority Ethnic population the largest single group is 'White: other than British or Irish' (at least 4,300 people) and it is likely that many are Polish;
- Life expectancy at birth is significantly higher than nationally and regionally for males and females. Male life expectancy is 79.3 years compared to 78.6 years nationally, for females life expectancy is 83.6 years compared to 82.6 years.
- There are 1,900 deaths a year and 80% of all mortality in the county can be accounted for in three groups: circulatory diseases; cancer and respiratory diseases;
- There are 31,200 adult smokers in Herefordshire. However, 61% of current smokers (19,000 people) would like to stop; Smoking related admissions to Wye Valley Hospital account for £3.15m per year.
- Two in five adults report drinking alcohol above recommended guidelines at least once a week and the highest prevalence is found in residents in Hereford City. Alcohol related hospital admissions have increased to 3,500 in 2010-11 a 30% increase since 2007-8 and is second highest rate for West Midlands. The majority are emergency admissions at a cost of £4.6m for 2011-12.
- Hospital admissions are significantly lower than PCT comparator sites but elective admissions have risen by 12.4% from 2006-7 to 24,700 in 2010-11. Cataracts are

the commonest cause of elective admission, along with breast cancer and colo-rectal cancer; emergency admissions have risen by 11.6% since 2006-7 with approximately 14,850 admissions in 2010-11, a further 4,400 admissions relating to maternity services. The commonest causes of emergency admissions are complications in pregnancy, bronchitis/COPD and pneumonia.

- Dementia is a significant challenge to Herefordshire. It is suggested that two-thirds of people living with dementia are undiagnosed but currently there are 3,000 residents with the diagnosis.
- Immunisation rates have not improved for Herefordshire have slipped from 'above average' to 'poor'
- Herefordshire's economic output is low at £15,296 per head of population compared with £16,602 in West Midlands and £20,498 across England. Unemployment is low (2.8%) compared with England (4.0%). Female, young people and long term claimants are higher than previous years and there are more people claiming out of work benefit for health reasons than are unemployed. The working age population is less well qualified (14% have no qualifications in 2010) than across England (11%).
- There are a rising number of homeless applications from teenagers as a result of parents no longer able or willing to accommodate them. However there is also a need to build more accommodation suitable for older people within the local area they know.
- There are low levels of multiple deprivation. However, in several areas of South Hereford and Leominster there are some of the most deprived households in England for over 10 years, with Leominster Ridgemoor still the area with the highest percentage of children in poverty.
- Herefordshire still remains one of the least densely populated areas of the country with residents scattered across its 842 miles. 54% of the population lives in rural areas and 43% lives in the most rural locations. Recent surveys of Herefordshire residents have shown that some health services, GPs, Dentist and hospital visits, were felt to be difficult to access due to public transport links.

6. Clinical case for change

It is against this background, and the deteriorating position of Wye Valley Trust financially that the Herefordshire Clinical Commissioning Group with Wye Valley Trust clinicians and Herefordshire Council have been rethinking the clinical strategies that need to be employed over the next five years to ensure that the challenges identified within the Integrated needs assessment are being systematically dealt with.

A series of working groups have already been established and all groups are clinically led.

A) A **Steering Group –** will lead the process it will be responsible for ensuring that

- The project methodology and timelines are adhered to
- Clinically/ financially robust proposals are developed with costs and milestones
- Sponsoring organisations and a critical mass of stakeholders support the agreed solution
- The updated service model is implemented

The Steering Group will be accountable to the Boards of HCCG and WVT and will report to the Herefordshire Health & Wellbeing Board.

B) Clinical/**Professional Strategy Group** will be responsible for the production of the updated health and social care model and plans. Specific tasks will include:

- Developing a Clinical Strategy for Herefordshire by February 2013 with a high level overview of priorities by the end of August 2012
- Auditing progress to date in delivery of the current model of integrated health and social care
- Identifying gaps in that model
- Developing an updated model which delivers the required cost improvements and maintains/ improves quality.
- Ensuring that any proposals are assessed for their impact on quality

The Professional/Clinical Strategy Group will quarterly and will be co-chaired by the Chair of HCCG and the Medical Director of WVT.

C) **A Pathfinder team** (Quick wins group) will support the CSG and will be chaired by the HCCG secondary care advisor. The Pathfinder Team (membership to be agreed) will be tasked with developing at high speed:

- an alternative model for care for an agreed service
- a non PBR funding solution providing an appropriate incentive to support this alternative model

Providing a template for use between meetings of the Clinical and Service Strategy Groups will be the implementation group which will track the progress and ensure new ideas are aligned into workstreams.

D) The **Implementation Group** will

- assist the Clinical/Professional Strategy Groups in auditing progress to date in delivery of the integrated model of health and social care and gaps in that model
- plan implementation of the updated model
- implement the updated model.

The Group will employ a Programme Management Office approach to support implementation of the agreed model.

Principles for clinical change

Out of the first deliberations of these groups have already come some high level principles that all organisations have agreed will start to address the issues:

- All phases of the strategy must be clinically led;
- Resources need to shift from treatment and hospital admission to health promotion, education and preventative strategies;

- Herefordshire residents should have services 'wrapped around them' so that they are enabled to stay in their own homes and localities for as long as possible;
- Care will be given closer to home and as a result of this the function and purpose of community hospitals needs to be reviewed;
- Patients, carers and the public should expect to be cared for on an integrated care pathway and not be concerned about organisational boundaries;
- In order to provide a safe and high quality service Hereford hospital services should be networked with other providers;
- The PbR funding mechanism needs to be re-examined for our health community and all other traditional funding streams in order to allow the shift to occur from hospital to community provision.

7. Pathway development

In order to work on each service and be innovative a recognised methodology will be used on pathway development. Both the HCCG and Wye Valley Trust have agreed that the Map of Medicine will be the clinical decision tool to be used in redesigning pathways, clearly designating which parts of the pathway are carried out in primary and secondary care. Support and guidance has been sought from Map of medicine and this system will be deployed following training for both clinicians, social services and partners. Both Secondary care Consultants and GPs will develop the pathways and will ensure that they are agreed with social service colleagues. The CCG has identified a programme manager post to be the map of medicine support manager and secured the services of Sir Muir Gray to facilitate the introduction and on-going clinical strategy work.

The first pathways to be tackled will be those relating to care of the elderly services, frail elderly and dementia services. This is to align with the integrated needs assessment but, in addition, will also start to address some of the long term condition pathways that will need to be implemented so that patients and carers can have services wrapped around them rather than admission to hospitals.

However, there is recognition that Wye Valley Trust must play its part in the wider health community of West Midlands health services and as such development of networks will be positively encouraged as part of the organisational development of the Trust. Already the CCG and Trust have participated in a review of Stroke services and are working with colleagues across Worcestershire/Herefordshire/Powys footprint to ensure a new way of delivering stroke care can be delivered for the population. The strategy will continue to build on this way of working, using Map of Medicine agreed pathways.

8. Next developments for community services

During the first phase a significant amount of development will need to be undertaken in primary care to ensure that the activity and capacity are aligned across the health system. To date the GPs and primary care have not been aligned with the integrated care system

and this has caused tension in the system. The CCG is talking to a range of providers about how services could be developed and how they could be geographically located. As part of this agenda the HCCG/Local Authority have worked on a specification for neighbourhood teams. This is the first specification produced by the commissioners and it is intended the next specification will be for 'virtual wards' so that patients can be discharged back to their homes rather than to community hospital beds. Following on from this will need to be a reconfiguration of the services for the community hospitals which the CCG wishes to see become Community Resource Centres with the remit of ensuring patients have services provided to them in their localities i.e. Outpatient services and has a more positive message of health improvement and prevention rather than a sickness service. All of these potential developments will need to be further worked up but the underlying premise is that they will release money from the acute services to be redistributed into community based services. This work will be subject to a S242 order under the consolidated NHS Act 2006.

9. Next developments for acute services

The acute services will need to change in line with the development of community services but in order to have effective community services there needs to be clinically safe and patient centred acute services. Clinical discussions have lead to the need to ensure that there will always be an Accident and Emergency/Trauma unit available as well as a Maternity service in Herefordshire. This is because of the geographical and social reasons and the fact that Wye Valley Trust serves 8,400 people from Wales for Powys Local Health board. In order to have a fully functioning unit there needs to be consideration of a number of important co-dependencies:

Services relating to acute medicine; acute surgery; trauma in relation to trauma and orthopaedics; anaesthetics; paediatrics and obstetrics. There will also need to be access to Pathology and Radiology as well as provision of a Cardiac Care Unit and an Intensive Care Unit.

This needs to feature heavily in the on-going development of the clinical strategy but there must be focus on a) which services can be shared/networked; b) does elective surgery need to be so closely aligned to the current service configuration and c) what tertiary services can be repatriated/provided from other Hospitals to Herefordshire so patients can have care 'closer to home' but help to sustain the hospital as the CCG and Local Council commissioners realign services into community and primary care provision.

As part of this shift of services the CCG and Local Council will want to look at innovative ways of working with the Wye Valley Trust and the clinical strategy group are looking at ideas generated from other groups and CCGs such as getting consultants to triage referrals to ensure patients are seen in the correct clinics, to creating a community management plan that GPs can implement, to asking Secondary Care Consultants to manage the programme budget spend on a pathway approach to release savings that can be released to invest in innovation and other development needs.

10. Information

The clinical strategy and revised model will need good, clear sources of information to aid the clinical decisions making process. As discussions have gone on the need for an information management and technology strategy has become clear. To date there has not been a whole system approach to information management or data collection or a financial strategy to fund the hard and software requirements and this will need to be addressed as part of the Herefordshire clinical strategy going forward, so that there is a clinically useful flow of patient centred information.

11. Market Management

The CCG and Local Authority commissioners wish to see innovation in provision and to develop other providers by bringing them into the providers market. Work will need to be undertaken to develop the market and provide choice for the people of Herefordshire to ensure that they remain active and part of their communities for as long as possible. Herefordshire CCG and the Council will undertake modelling of demand and supply for a five year cycle as part of the financial strategy as well as applying scenario planning to the models. As part of this work we will adopt a proactive approach to market development by working with existing NHS, independent and voluntary sector providers to ensure continued provision of quality services. We want to see all current providers develop high quality but cost effective and appropriate services. Where existing providers cannot meet the needs of Herefordshire residents in terms of cost or quality we will explore the potential to introduce alternative providers from NHS, independent and voluntary sectors as a means to seeking innovative solutions to our commissioning intentions. Herefordshire CCG will also use the route of any qualified provider to develop the market as well as tendering of services where appropriate. By developing the market management strategy with the clinical strategy there will be an opportunity for providers to innovate services but it will mean for certain conditions a reduction in secondary care activity and an increase in community and primary care based activity.

Cathy Gritzner – Chief Officer (Designate)
Jill Sinclair – Chief Financial Officer
31st August 2012

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 SEPTEMBER 2012**
TITLE OF REPORT:	**WEST MERCIA CLUSTER QULAITY HANDOVER BRIEFING**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To note the quality handover briefing.

Recommendation(s)

THAT the quality handover briefing be noted.

Introduction and Background

1 The briefing is appended.

Background Papers

- None identified.

Further information on the subject of this report is available from
Lin Jonsberg, Board Secretary, West Mercia Cluster on 01432 260308

Background

The Health and Social Care Act 2012 requires the new system architecture for the NHS to be in place by the 1st April 2013. The implementation of this new architecture will require significant changes to be made to most parts of the current system. The Department of Health and the National Quality Board has recognised that this level of structural change has the potential to put quality and safety at risk as quality functions, governance structures and assurance mechanisms are being transitioned to the new model. To ensure that any potential risks to quality and safety are identified and managed during the transition the National Quality Board is requiring PCT Clusters to complete a quality handover plan. The structure of this plan is defined in the National Quality Board paper - How To: Maintain Quality during the Transition: Preparing for Handover (National Quality Board, 2012) with the key elements being:

- Identification of the functions and responsibilities of sender organisations that are expected to close down or transfer
- Identification of receiving bodies and the information that they will need
- Definition of a process for handing over quality functions that include transfer of soft and hard intelligence
- Plans for resilience to ensure that accountabilities for quality and handover are deliverable
- Governance arrangements to ensure transparency, honesty and probity during the transition.

Scope

On 23rd June 2012 the West Mercia Cluster submitted an initial plan for creating a quality handover document for receiver organisations (see Appendix D). This paper is presented to the West Mercia Cluster Board so that it may note in public session the submission to the Strategic Health Authority of the outline plan and identify the key actions needed to support the development of the quality handover process.

Key Milestones

The following timetable outlines the nationally set key milestones for quality handover.

September 2012

- Version 1 of the quality handover document complete ready for submission to SHA Cluster and National Quality Board

October 2012 – December 2012

- Organisations maintain and update quality handover documents as NHS Architecture begins to change
- National Quality Board visit SHA Clusters to gain assurance that appropriate quality handover plans are in place

January 2013 – March 2013

- Quality data kept live and handover document revised to reflect current circumstances
- Final quality handover document approved by final board meeting of sending organisation in March 2013.
- Approved version sent to receiving organisations and Nation Quality Board

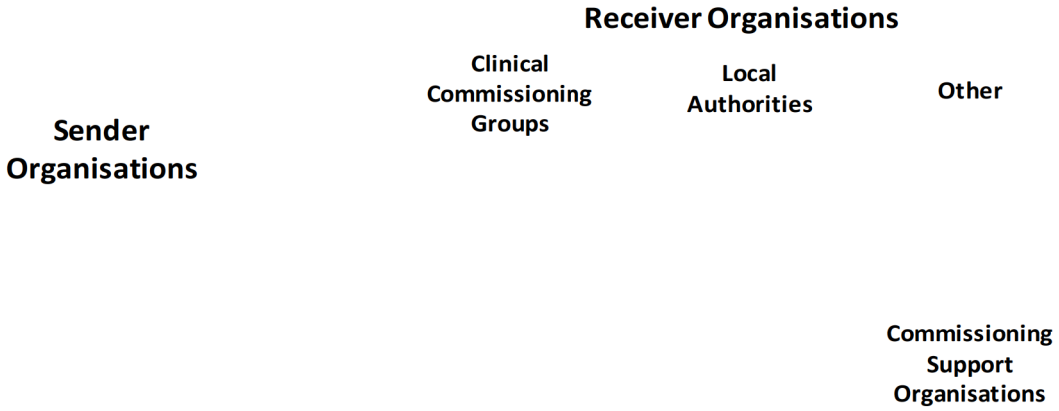
April 1st 2013 Accountability Transfers

- Receiving Organisations adopt all relevant documents formally at fist public Board
- Receiving organisation develop and agree action plan for taking forward quality issues

Sender and Receiver Organisations

The West Mercia Cluster plans for the creation of quality handover documents identify the sender and receiver organisations shown in figure 1. As the handover document develops it is probable that this number of receiver organisations will increase as the transfer of specific functions are defined in detail.

Figure 1 West Mercia Sender and Receiver Organisations



Appendix A of this document provides a more detailed list of the key questions that need to be considered by sender organisations. Appendix B provides a similar checklist of receiver organisations.

Functions and Responsibilities

West Mercia Cluster through its constituent PCT's has identified a range of statutory functions and responsibilities that need to be passed on to successor organisations. These duties have been categorised into eight areas and then assessed to see which have a quality dimension. The eight categories are:

- Overall Duties
- Strategic Leadership
- Partnership Engagement and Advocacy
- Providing or Securing Services
- Monitoring and Evaluation
- Accountability and Assurance
- Workforce
- Estates and IT

The detailed quality function mapping for each category will be finalised in July 2012 and will be available on request from Simon Collings – simon.collings@nhs.net. In August 2012 a list of quality functions and responsibilities transferring to each receiver organisation will be produced for circulation in August.

Quality Information

The National Quality Board has identified two categories of information that need to be captured for the three domains of quality: effectiveness, safety and patient experience.

Category 1 – Hard Data

This is quantitative and qualitative recorded data that is used as the basis of performance metrics and quality assessments. The four PCT's in the West Mercia Cluster have already undertaken a considerable amount of work to identify the information requirements for the receiver organisations as part of the preparation of Legacy documents. This work will be expanded on to form the core of the quality handover plan.

Appendix C provides a list of potential data sources. Please note that this is not a comprehensive list and should be expanded as necessary.

Category 2 – Soft Intelligence

Soft intelligence is the term used by the National Quality Board to describe information that cannot always be verified or proven. This may be anecdotal evidence or even a feeling that something is not quite right. If the sending organisation is aware of concerns that are not yet verifiable or able to be captured they should share this information verbally at face to face meeting as part of the quality handover.

As part of its quality handover plan West Mercia cluster will be setting up a series of face to face meeting between staff in sending and receiving organisations to ensure the transfer of soft intelligence.

Governance

In the West Mercia cluster the quality handover will be overseen by a task and finish group whose membership will include representatives from sender and receiver organisations in the region. The Quality Transition Lead for the Cluster will be the Chief Executive – Eammon Kelly. The PCT Cluster Leads for the quality handover are:

- Sue Doheny, Director of Nursing
- Kiran Patel, Medical Director

The first meeting of the Task and Finish Group is planned for August 2012.

Key Activities July – September 2012

Table 1 below sets out the key activities that need to take place across the West Mercia Cluster to ensure that the first National Quality Board milestone is met. The plan submitted to the SHA on the 23rd June 2012 is included within Appendix D of this document.

Table 1.

Activity	Due Date	Lead
Quality Leads identified by receiver organisations	Jul	Receiver Orgs
Task and Finish Group Established	Aug	SD/RM/SC
Workforce Resilience Protocol and Plan	Aug	SP
Alignment of legacy quality functions with receiver business models	Aug	SC/RM
Risk registers established in receiving organisations and aligned with senders	Aug	SD/RM/LJ/Receiver Orgs
First Draft of Quality Handover document	Sep	SD/SC
CCG Quality Assurance frameworks in place	Sep	CCG AO
QPR Report on outstanding legacy issues	Sep	SD
Set up Stakeholder Workshops	Sep	LJ/SC

Key

SD – Sue Doheny
SP – Suzanne Penny
RM – Richard Miles
LJ – Lyn Jonsberg
SC – Simon Collings
CCG AO – CCG Accountable Officer

A progress update will be provided to Cluster Executives on a monthly basis. In September this will include the key activities for the next period. A draft schedule of key activities for 2012/13 is available from Simon Collings – simon.collings@nhs.net.

Summary

West Mercia Cluster has submitted initial plans, for maintaining quality and safety during the transition to the new NHS architecture, to the SHA and National Quality Board. The primary focus of these plans over the next 2-3 months will be the development of a quality handover document. A quality handover task and finish group will manage the handover process and ensure the delivery of the key milestones set out in this paper.

Quality handover questions to be considered by Sender Organisations

Questions
• Is my organisation being abolished or reformed? (Changes to function responsibilities should also be subject to quality handovers)
• Are my functions being closed down or transferring?
• If transferring, are they all going to one organisation or several? (If several, identify them all)
• If some of my functions are not being transferred to anyone, is this because a receiver has yet to be identified, or because they will not exist in the new system? Does this present any risks, and how might they be mitigated?
• Who are the customers for my information on quality?
• What are their particular needs? What information will they need access to and how can I provide the information in a way that is most useful to the user in the time and format that they need?
• Do I have all the information I need on quality for my areas of responsibility? If not, what steps do I need to take to fill those gaps prior to the deadline?
• Who will I need to talk to in order to fill the gaps in both hard and soft intelligence? Can I get them in the diary now?
• Who will I need to talk to/work with in order to triangulate my information on quality
• What processes do I need to put in place to prioritise any risks identified, so that the user can easily see the greatest risks to quality, perhaps in the form of a summary risk profile?
• Of those quality risks identified, is there any good reason why I can't tackle and resolve them by April 2013?
• Are there historic issues that have been resolved, but may need follow through in terms of Action Plans and other recommendations, or that I should alert the new team to in case of reoccurrence?
• Do I have processes in place to capture quality issues in primary, social and independent care sectors?
• Am I clear about what information I will convey in written documentation and what I will communicate verbally and why?
• Have I put in place a process of internal triangulation, so that my functional leads can share what they have learned and understood about quality from their different perspectives/sources?
• Have I diarised meetings enough time between the key people to ensure we have face-to-face meetings following receipt of the documents? (From our experience a robust quality handover conversation with documents should take at least half a day).
• Do I have HR processes in place to ensure that key staff don't leave before documenting their knowledge and/or taking part in the vital handover conversations?
• Do I have a resilience plan in place so that I can maintain a)current responsibilities for resilience and b)have senior staff who can participate in the conversations about handover?
• Am I clear about the requirements of FOI, and have a strategy to meet them whilst also ensuring the frank exchange of information necessary to maintain quality of care?

- Do I have a process of triangulation of the data and intelligence I am likely to send with external bodies? (Our current thinking is that PCT Clusters should triangulate with local bodies, such as OSCs and LinKs, but that SHA Clusters should triangulate face-to-face with national bodies at sector level, such as CQC and Monitor, and that we the NQT would triangulate face-to-face with the national offices of CQC and Monitor)
- Have I identified contacts in my team who will be in the new system and who could contribute to the delivery of corporate memory following handover?
- Do I have processes and people in place to keep the data live between September 2012 and April 2013?
- Are my team clear that until 1st April 2013, we retain our current statutory accountabilities? No matter who we send information and documents to, you retain responsibility for acting upon the information until the accountability transfers.
- Do I have sufficient safeguards in place to ensure full probity? (particularly where dual accountability is an issue either at CEO or Director level).
- Is my documentation easy to read, accessible to all and stored in accordance with the guidance on P19?

Quality handover questions to be considered by Receiver Organisations

Questions
• Am I clear about what responsibilities I will carry with regard to quality, and how I will exercise them and what information will I need in order to carry them out?
• Who, if anyone, currently holds those responsibilities and information now?
• Are they clear about my imminent responsibilities and my needs and expectations of them with regard to handover? Do I need to meet/communicate to ensure clarity? Do not assume they do – take proactive steps to contact them and set out your expectations.
• Have I identified a Transition Lead to manage the receipt of functions, accountabilities and knowledge from the old system, as distinct from the staff I have working on the new?
• Have I diarised meetings enough time between the key people to ensure we have face-to-face meetings following receipt of the documents? (From our experience a robust quality handover conversation with documents should take at least half a day).
• Am I clear how and when I will gain access to the documents and what I should do with them?
• Have I viewed the work in progress handover documents, and am I ready to receive and exercise my responsibilities with regard to quality on April 1st 2013?
• Do I have in place a process of triangulation of the data and intelligence I am likely to receive with external bodies? (Our current thinking is that PCT Clusters should triangulate with local bodies, such as OSCs and LinKs, but that SHA Clusters should triangulate face-to-face with national bodies at sector level, such as CQC and Monitor, and that we the NQT would triangulate face-to-face with the national offices of CQC and Monitor).
• Have I put in place a process of internal triangulation, so that my functional leads can share what they have learned and understood about quality from their different perspectives/sources?
• Have I identified a board meeting to receive and discuss the handover documents? Do I need a private session first to share soft intelligence?
• Do I have robust systems in place to ensure full probity, and the ability to challenge with diligence the information I am presented with? (particularly in the case of dual accountability)

Quality Handover – Sources of Hard Data

- Performance data on the priorities set out in the Operating Framework relevant to quality (i.e. waiting times, infection rates etc.)
- Never Events and serious incident data
- CAS alerts closure rates and outstanding issues
- Hospital Mortality
- Patient survey results and other patient data such as Net Promoter scores if available and website material such as NHS Choices)
- Staff survey results
- Complaints data
- CQC inspections - registration details, warning notices and related CQC notifications
- Quality Risk Profile data
- FT Quality assessments
- Monitor ratings
- Quality Accounts
- Adult safeguarding
- Child safeguarding
- Safety Thermometer and Energising for Excellence
- Maternity Services, Local Supervisory Midwifery Authority reports and audits
- Data from the Quality Observatory
- Quality impact assessment of Provider Cost Improvement Programmes
- Homicides/unlawful killings – historic and ongoing including action plans
- Peer reviews, recommendations and action plans
- Clinical Audits

Section 1. Overview: Who we are, what we do, and where will our key responsibilities go?

West Mercia PCT Cluster comprises 4 PCTs:
NHS Herefordshire;
NHS Shropshire County;
NHS Telford & Wrekin;
NHS Worcestershire.

The PCTs have a range of functions, including commissioning health care for their respective populations and the provision through contracts of primary care services.

These 4 statutory bodies and the Cluster will be abolished on 1 April 2013, but in the mean time there will be a progressive handover of responsibilities to other bodies, initially through delegation and then absolutely when different statutory bodies are established.

This plan shows how we intend to pass on quality information and responsibilities to successor organisations, including Clinical Commissioning Groups, the National Commissioning Board, and Local Authorities.

The PCT Cluster leads for this Quality Handover Plan are:

- Sue Doheny, Director of Nursing and Dr Kiran Patel, Medical Director, NHS West Mercia PCT Cluster

Section 2. What are our current functions and responsibilities?

We have identified the range of functions and responsibilities that the Cluster (through its constituent PCTs) has a statutory duty to fulfil, and which must therefore be passed on to successor organisations insofar as a statutory duty will remain from April 2013. These are shown in **Annex A**, which is based on a paper considered by the Cluster Board in May 2012.

We have identified in Annex A the functions that have a particular quality dimension, because the Board has been considering its full range of handover responsibilities, some of which will be covered in separate, complementary plans that do not specifically deal with quality.

This plan follows guidance issued by the National Quality Board (*How to Maintain Quality during the Transition: Preparing for handover*, May 2012) and other plans will follow expected further guidance from the Department of Health.

Section 3. Where will our functions transfer, and what are the information needs of our recipients?

Annex A shows in broad terms, based on current knowledge, the recipient bodies for

quality handovers from the West Mercia PCT Cluster.

More specifically, we have identified the successor organisations to which we intend to pass on quality information and responsibilities as:

NHS Herefordshire CCG
NHS Redditch & Bromsgrove CCG
NHS Shropshire CCG
NHS South Worcestershire CCG
NHS Telford & Wrekin CCG
NHS Wyre Forest CCG
(**Annex B** contains some more information about the CCGs)

National Commissioning Board
Commissioning Support Organisations (identity to be confirmed; functions will be handed over by CCGs)

Health and Wellbeing Boards and Public Health functions at:
Herefordshire County Council
Shropshire County Council
Telford & Wrekin Council
Worcestershire County Council

Public Health England

Given the number of successor organisations there will remain a risk that no one organisation has a comprehensive overview; we would wish to consider with the NCB options to address this.

The kind of quality information that these organisations will require to fulfil their responsibilities effectively arises from the functions being transferred to them. This is being identified by the directors and managers responsible for each of these functions in a process that has already commenced through the delegation of some functions to CCGs. This process of identification will continue through the CCG Authorisation process.

We will continue to identify:

- Quantitative information about performance and risks (and will use the NQB Dashboard when available)
- Information on historical issues and those that appear to have been resolved (referring for example to HCC / CQC and Prison health (PPO) reports; HSMR; and a comprehensive trackback to 2006)
- Qualitative and emerging soft intelligence.

We will use the disciplines of our QPR reports and CCG review meetings.

- Medical Director; Director of Nursing; Director of Finance; Director of

Commissioning Development; Deputy Chief Executive; Directors of Public Health

Section 4. How will we gather and collate the information that they need?

The Cluster's four PCTs have already undertaken a considerable amount of work in the preparation of their Legacy Documents to identify both the information requirements for their successors and the material that is available to pass on to them.

Work will also continue, building on the legacy risk registers, to identify potential risk areas for the effective handover of functions and information, for example in relation to the IT coding systems that underpin patient referral processes such as Choose and Book.

In addition, some functions have already been delegated to the CCGs, as committees of the Cluster Board, in preparation for their assuming full responsibility on the demise of the PCTs. Further functions will be delegated over coming months, based on dialogue between Cluster staff and CCG staff and on the Authorisation process.

Annex C identifies the current delegations to CCGs, which are subject to audit and assurance requirements. These delegations include quality functions, which will be identified in the specific handover documents that will be produced for each CCG.

In the period June to September 2012 further work will be carried out to pull together the quality functions and supporting information sources that will be required for inclusion in the Quality Handover Documents for each successor organisation. This will include the processes that the CCGs should follow in sourcing this information.

The data sources to be used for the quality handovers will be reviewed in the light of the work carried out for the previous legacy documents; the experience of delegation to CCGs; and the list provided in Chapter 4 of the NQB guidance.

- Medical Director; Director of Nursing; Deputy Chief Executive; Directors of Public Health

Section 5. What plans do we have to triangulate this data?

We will continue to move this work forward by identifying key officers across the cluster to provide refreshed information and co-ordinate handover work within their specific areas.

We will also ensure that handover work is integrated into the mainstream work of directorates and the key change programmes being implemented across the Cluster.

The Transition Lead and Governance leads will co-ordinate this information across the Cluster. The Board will continue to receive Performance and Quality Reports at each formal board meeting and these are also circulated to CCGs.

The front sheet for Board reports has been amended to include consideration of legacy/handover issues and all Committees of the Board and other critical groups are required to complete an Assurance pro-forma at the end of each meeting identifying key risks including legacy issues.

We will continue, with our partner organisations, to use our Quality Concern model to review and triangulate data. Where necessary this may lead to Risk Summits.

We expect to use the NQB Dashboard in this process.

Increasingly we will encourage CCGs to be a part of this approach, especially as they have more direct dealings with service providers and with other bodies such as the local authorities. This process will be overseen by the QPR committee.

The Cluster will meet with OSCs, LInKs, Local Health Watch specifically to ensure that any risks and issues are identified through triangulation, so that action plans to deal with them can be prepared, and successor bodies are notified through the handover process.

We will continue to take into account intelligence from such bodies as CQC, NHSLA, PPO, complaints and inquiries.

- Medical Director; Director of Nursing; Directors of Public Health; Cluster Board Secretary; CCG Governance Leads; Director of Commissioning Development

Section 6. How will we ensure face-to-face handovers?

We will prepare a schedule of dates for the final handover to successor bodies, taking into account the ultimate end date for the existence of the PCTs and the progressive handover of functions by delegation that is already underway. (See Annex D)

- Transition Lead; Director of Nursing; Cluster Board Secretary

From this, a plan for specific dates for face-to-face handovers will be prepared, identifying the responsible officers and dove-tailing with Cluster Board meetings so that the handovers (and the information contained within them) are endorsed by the Board.

The handover meetings process will include time for reflective feedback by the successor bodies, to ensure that the information can, when necessary, be challenged or verified.

- Medical Director; Director of Nursing; Directors of Public Health; Director of Commissioning Development; Deputy Chief Executive

Section 7. What plans do we have to ensure our handover plan is resilient?

We will appoint a Transition Lead for the Cluster, and in terms of Quality handover, the Medical Director and Director of Nursing will oversee the arrangements.

Each Director and senior manager will ensure, with the assistance of HR, that handover intelligence is captured before any member of staff leaves – whether from the PCT Cluster or from the CCGs prior to April 2013.

- All Executive Directors, Non-Executive Directors and Senior Managers

Staff of the CCGs, whilst they remain committees of the Cluster Board, also have responsibility for ensuring a resilient handover; it is in the interest of the services for which they will be fully responsible following the demise of the PCTs.

- COOs of the CCGs.

Progress towards handovers, and any risk factors, will continue to be monitored by the Audit Committee QPR Committee and the Cluster Board via a Task and Finish Group.

Section 8. What Governance arrangements do we propose putting in place to ensure transparency, probity and honesty?

[

The handover arrangements will be kept under review by the Cluster Board and on its behalf by a Task and Finish Group (led by a NED) reporting directly to the Board; by the Audit Committee (which is the mechanism for ensuring financial probity and good governance; its minutes will be in the public domain. It will continue to review risk registers and ensure CCGs receive guidance on governance and audit requirements including conflicts of interests, gifts and hospitality); and by the QPR Committee.

We will ensure that key policy documents will be available on the website supporting the West Mercia Cluster governance agenda.

Board and Committee members will continue to be required to formally declare any interests (including any assumption of responsibilities in successor organisations) at each meeting, which will be recorded in the Declarations of Interests register.

A central risk register is maintained which records the most serious risks and reports these to both the Audit Committee and Cluster Board bimonthly.

The Custer complies with the FOI Act in recognition of the Government's commitment to greater openness. However, it will not publish information or grant requests to release

information if it is subject to the Data Protection Act 1998, for example if the information contains personal/sensitive data or breaches confidentiality.
Section 9. Key milestones
See **Annex D**
Section 10. Annexes [Any further information you feel may be relevant to provide assurance that you have an effective plan to develop quality handover documents in line with the guidance.]
Annex A PCT Functions and Duties – Managing the Transition – Handover to Successor Bodies Annex B Prospective CCGs to receive quality information Annex C Current Delegations to CCGs Annex D Key Milestones for Quality Handover Plan All Appendices are available on request from Simon.collings@nhs.net

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
DATE:	**18 SEPTEMBER 2012**
TITLE OF REPORT:	**UPDATE ON FINANCIAL POSITION FOR ADULT SOCIAL CARE AND ROOT AND BRANCH REVIEW OF OLDER PEOPLE**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To update the Health and Wellbeing Board on the in-year financial position of adult social care, including measures to achieve transformation and savings. To provide an update on the work of the root and branch review for older people.

Recommendation(s)

THAT: the Health and Wellbeing board consider how all partners can tangibly contribute to the transformation agenda for adults and older people services, assist with the 2012/13 budget position and achieve a sustainable budget across the system.

Key Points Summary

- The adult social care service area has challenging targets for transformation and savings. The approach has been captured in the Strategic Delivery Plan to Transform Adult Services 2012 - 2015, which will be monitored through a sub group of the health and wellbeing board.
- The scale of the challenge for Herefordshire is greater than for statistical neighbours. Herefordshire has historically overspent year on year

How will your report meet the vision and guiding principles of the HWBB?

The report sets out financial challenges which cover services that contribute to the Health and Wellbeing strategy vision and guiding principles, particularly in relation to people's wellbeing, and living independently for as long as possible.

Alternative Options

1 No alternative options as this is an update report

Further information on the subject of this report is available from
Chris Baird, Assistant Director People Services (01432) 260264

Reasons for Recommendations

2 The Health and Wellbeing Board has an opportunity to consider how it can make a significant impact in-year and also over the longer term.

Introduction and Background

3 Budgets across health and social care are under significant in year pressure, within a context of increasing demand and a history of overspend and budgets being balanced through injections of in-year additional resources or end of year adjustments. The recent white paper "Caring for our future" addresses a range of service issues and is intended to focus on people's wellbeing and enable them to live independently for as long as possible. However, it does not fundamentally address funding issues for social care at a national level. Herefordshire faces particular demographic challenges which accentuate the national picture and has a range of initiatives taking place to transform services, captured in the Strategic Delivery Plan to Transform Adult Services. Multi agency involvement is critical to the success of this plan and the delivery of Herefordshire's vision for health and wellbeing.

4 Herefordshire Council has undertaken a programme of root and branch reviews to assess the role of the council in the future in relation to the expectations of citizens, the nature of services (both commissioning and provision) and what can be done in anticipating future budget reductions at a national level. The review of services for older people has begun and has moved through the initial scoping and discovery phase. This report provides an overview of these two phases.

Key Considerations

4 The Adult Social Care Budget Plan has been set to deliver £7.956 million. This is alongside the wider context of savings and budget challenges across the health and social care system. Wye Valley NHS Trust has a predicted deficit of £9.6m and there is a CCG QIPP plan set to deliver £10m (July 2012).

5 £981k savings have been achieved to the end of July on the adult social care budget with a further £521k identified, subject to audit confirmation giving a potential total of 1,502m compared to a target profile of £1,186m

6 Currently there are 4 schemes within the transformation plan with a total value of £3,225m, where £2.472m of this sum is currently rated as red risk to being achieved. There are a number of schemes flagged as amber. Ten schemes have a green status and total £1,523k A robust approach is being taken to savings to ensure they are real, delivered and not double-counted.

<u>In-Year Pressures</u>

- The Adults Budget is regularly re-assessed. Significant work has been undertaken to bring forecasting up to date and to regularise the inclusion of previous commitments into the forecast. Although additional resources were committed for new cases, at this point in the year, costs of support are creating a significant budget pressure, particularly in domiciliary care for older people, ageing carers and mental health. Mental health is also causing a budget pressure for the Primary Care Trust. This could result in significant additional pressures in year for adult social care, although further work is being undertaken to challenge this and ensure this position is correctly set out.

- Other options for consideration in addressing the budget pressures are :

- Reviewing the policy framework, including reviewing eligibility criteria.
- Delivering only statutory services, with risks to prevention and diverting demand
- Introducing waiting lists for services
- The potential impact of these options and others are being explored so that the director and lead member can make informed decisions in the context of budget management.

National / Regional Position

The recent Association of Directors of Adult Social Services survey of all local authorities indicated that budgets are under pressure, though the extent varies by authority, as does the level of funding to meet demographic pressures and budget savings targets. This work is being analysed in detail to assess Herefordshire's approach.

Root and Branch Review of Services for Older People

7. The initial phase of the review involved a range of activity including reviewing current plans for transformation, benchmarking service activity and costs, and two whole day workshops involving a range of managers and staff from different organisations. The general findings are summarised as follows:

8. The benchmarking exercise highlighted the following areas worth investigation:

- A declining trend in the number of older people receiving residential and nursing care services
- Lower than comparator group and all England average, but a rising trend in admissions to nursing care
- Significantly lower share of council's spend on residential and nursing care for all client groups covered by client contributions (7.5% vs 11.6% in comparator group)
- Unit costs for residential care where it appears Herefordshire is spending more on fewer weeks of care compared to some other authorities. Based upon 2010/11 data Shropshire, for example, commissions 94% more resident weeks than Herefordshire for 80% more spend. So, to achieve the unit cost per resident week of residential care of the "average" council in Herefordshire's comparator group (Shropshire at £470 per resident week) an increase in value for money (i.e., more resident weeks for the same amount of spend) of £862k would be required, a 7.5% change.
- Domiciliary care unit costs which are 10% higher than the mean for nearest neighbours. For example, Herefordshire spends 18% more than Bath and North East Somerset on commissioning domiciliary care services, but for only 5% more client weeks. To achieve the unit cost per client week of domiciliary care of the "average" council in Herefordshire's comparator group (Bath & North East Somerset at £191 per client week) an increase in value for money of £947k would be required, an 11% change.
- Direct payments unit cost appears to be almost three times higher than the all England average. To achieve the unit cost per client week of direct payments of the "average" council in Herefordshire's comparator group (Central Bedfordshire at £179 per client week) an increase in value for money of £605k would be required, a 49% change.

9. The workshops confirmed current areas covered by the improvement and transformation programme.

- More frequent reviews to ensure appropriate levels of care for the correct length of time
- Reductions in block contracts to minimise voids and reduce costs
- Market development with more flexible contract models
- Use of care funding calculator to ensure initial packages are set at appropriate level
- Consultation on increasing charges for those that can afford to pay
- Using assistive technology to keep people independent longer
- Ensuring equity and quality of support to carers
- Increase use of supported accommodation rather than residential placements
- Delivery of local, preventative support through neighbourhood teams and multi disciplinary approaches
- Engaging wider service areas rather than simply focusing on adult social care and health to enable individuals to live independently
- Development of a range of policies to establish appropriate case and funding decisions, based on the principle of "just enough" care and support

10. The current planned range of activity therefore needs to be augmented by the following:

- Addressing unit cost variations as detailed in the benchmarking reports, achieving preventative outcomes, appropriate dignity and safety whilst providing "just enough" care or facilitating individual commissioning within budget goals
- Decision on what the balance should be between the council commissioning services or self funders and personal budgets
- Dementia services, focusing on proven activities that maintain independence, in partnership with the CCG
- Delivery of the frail elderly programme in partnership with the CCG
- Review of major contracts, even if recently reviewed (in the last 18 months) to determine whether they offer best value, should still continue, be revised

11. Fundamentally Herefordshire should concentrate on changing the pattern of demand, involving wider services and stakeholders. This includes the further development of preventative approaches including information, guidance and sign posting to individuals and importantly families, future carers and carers, and approaches such as adaptive technologies, reablement. It would include moving from buildings based provision to community based provision (including options for community asset based approaches such as time banks. Strategic decision also need to be taken whether the council should continue to own and act as landlord for buildings that provide services, with some

evidence that the current unit cost (based on 2010/11 unit cost data) for some of this provision is £316 per week compared to £135 per week externally.

12. The work so far is now subject to a challenge panel approach before being discussed by Cabinet. In October. A programme of work will then take place to engage people and partners.

Community Impact

13. Issues for older people and for the vulnerable key priorities for both the council and the health and wellbeing board. The development and change of service provision will affect communities across Herefordshire and require consultation and involvement.

Equality and Human Rights

14. These are important aspects that are considered at points of development and change.

Financial Implications

15. The Council is facing significant challenges in financial terms and through the national settlement and reductions in funding. The Council's five year financial strategy includes an estimated 29.7% reduction in government formula grant. Budget decisions have been based on a set of core principles that include Supporting the Vulnerable. The process also includes fundamentally challenging what the council does to ensure appropriate use of public funding and quality of service

16. These are set out in the body of the report

Legal Implications

16. None in terms of this report.

Risk Management

17. Risks to council services from a financial point of view are significant. As with the national position, locally the council cannot afford to continue with the pattern of spend that has been taking place over the past few years in relation to adult social care when married with the forecast increases in demographic pressures and increased levels of need.

Consultees

Not applicable

Appendices

None

Background Papers

None identified